NAVY FAMILY SERVICE CENTERS

CLINICAL Counseling

DESK GUIDE • VOLUME 5

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FOREWARD

This *Clinical Counseling Desk Guide* is addressed to Navy Family Service Center (FSC) Directors, Clinical Counseling Supervisors, Clinical Counseling Staff, and FSC Program Managers. This guide is a reference tool for FSC clinical providers who provide clinical counseling services. It is intended to be the foundation for clinical counseling protocols, standard operating procedures (SOPs), and overall delivery of clinical counseling services.

The purpose of the *Clinical Counseling Desk Guide* is to provide reliable information, ideas, and tools to manage Clinical Counseling Services in the local FSC. Developing an effective program is an evolving process which must be strategically planned and supported by adequate staff and resources. It is your challenge to appropriately apply the accreditation quality standards and guidelines contained and referenced in this guide based on your knowledge of your FSC, the resources and mission of your installation, and how to best serve the military members and the military families in your local area. It is recommended the *Clinical Counseling Desk Guide* be supplemented with local resources, phone numbers, and related SOPs.

Clinical Counseling services are vital in providing support to military members and to families; establishment of guidelines is essential to ensure quality services. The *Clinical Counseling Desk Guide* is intended to clarify roles and responsibilities, functions and services of the FSC clinical counseling staff. The information contained in this guide should serve as a benchmark for the planning, management, and evaluation of your clinical counseling services.

PREFACE

The FSC Desk Guide Series represents the best professional practices for FSC operations. FSCs are the primary delivery system for all family support programs.

Volumes I and II are identifiable by their white covers.

- **Volume I:** FSC Management and Operational Overview
  Part 1 briefly reviews the mission, objectives, basic functions, core programs and programs elements, organizational structure, responsibilities of the director and deputy director, and eligible persons. Part 2 expands on those responsibilities. FSCs are dynamic organizations in a dynamic, changing environment and must continuously adapt to changes and demands from the fleet and the service users. To facilitate updating, the Desk Guides are contained in three-ring binders that allow easy insertion of new and updated material, some of your own making and others that will be issued periodically by the Navy Personnel Command (NPC).

- **Volume II:** Overview of FSC Functions, Programs and External Linkages and describes the three functions of a FSC:

  1. Information and Referral (I&R)
  2. Education and Training
  3. Counseling

  It further outlines the programs and program elements and describes the FSCs coordination role and key external linkages with military and civilian communities.

- **Volumes III - XIX:** The blue cover series of the Desk Guides describe in detail the design and implementation of FSC programs.

We welcome comments on how this Desk Guide can be made more useful. Please send suggestions to PERS-66.

ACKNOWLEDGMENTS

Providing clinical counseling services for sailors and for families is one of the primary functions of Navy Family Service Centers (FCSs) worldwide. The original Counseling Desk Guide was introduced in 1993 in order to provide the highest standards for services provided around the world. This volume of the *Clinical Counseling Desk Guide* represents a revision of the original document. As with the original project, valuable assistance was provided from FSCs worldwide. When the Personal, Family, and Community Support Division (PERS-66) requested information from FSCs regarding the effectiveness of the existing Counseling Desk Guide, they eagerly responded with a wealth of information.

Clinical providers and Chief of Clinical Services from over 30 FSCs worldwide responded to an evaluation of the original Counseling Desk Guide. Many of their ideas and current practice information are included in this revision. An additional 10 sites participated in the final edit of the *Clinical Counseling Desk Guide*. These sites included FSCs located at Whiting Field FL, Marietta GA, Gaeta Italy, Patuxent River MD, Meridian MS, Willow Grove PA, Charleston SC, Rota Spain, Kingsville TX and London UK. These FSCs provided invaluable feedback about the accuracy and effectiveness of the *Clinical Counseling Desk Guide* and their feedback has been incorporated throughout this revised *Clinical Counseling Desk Guide*.

Maintaining a high quality clinical counseling program at the FSC is an important component in enhancing the quality of life for active duty personnel and for military families. Healthy, well functioning personnel contribute to the successful completion of the Navy mission. This guide is a reflection of the dedicated staff at FSCs worldwide who are committed to this goal.

PART ONE:
Navy Family Service Center (FSC) Clinical Counseling Services: An Overview

FSCs exist to provide services which facilitate personal and family readiness and adaptation to life in the Navy. The primary mission of each FSC is to assist commands in achieving operational readiness, superior performance, member retention, and a reasonable quality of life for Navy personnel and their families. Commands and FSCs share the common goals of keeping individuals and families healthy and strong, preventing individual and family dysfunction, facilitating personal and family self-sufficiency, and creating overall command and community wellness. (FSC Master Plan, 1998)

1.1 BACKGROUND

SECNAVINST 1754.1 established policy for FSCs in 1984. In 1992, the Department of Defense (DoD) Instruction 1343.22 required core FSC services to be available for all military service and family members throughout the DoD. In 1995, the Secretary of the Navy directed that a Comprehensive Assessment of Quality of Life Programs be conducted and a Master Plan be developed for FSC Programs. This Master Plan was incorporated into the revised SECNAVINST 1754.1A issued in 1999.

Since their inception, FSCs have included clinical counseling services which are offered to meet the needs of service members and their families. With the development of the FSC Master Plan (1998), clinical counseling continues to be an integral part of the FSC mission, becoming one of four Readiness Support Capabilities of the FSC. In 1993, Accreditation Quality Standards were developed and implemented to reflect achievement of excellence through continuous process improvement. Clinical providers represent an essential part of an overall team of FSC professionals who work together to:

- Increase the Navy's operational readiness by supporting commanding officers and providing information, education, and counseling services to sailors and to families.
- Improve the overall quality of life of all sailors and families.
- Provide support services for active duty members of the other Armed Services as required and for reserve and retired members whenever possible.
- Be flexible in providing the services most needed by their customers and work together as a team toward that goal.
- Share resources within regional areas—create partnerships within the local community and utilize technology to maximize the return on investment at all FSCs Navywide.

1.2 PHILOSOPHY OF FSC CLINICAL COUNSELING SERVICES

Throughout the course of a Naval career, service members (single and married) and/or their family members encounter problems or crises which require the professional attention of a clinical provider. Use of FSC clinical counseling services can directly improve quality of life. Today, military leadership recognizes a service member's readiness to perform his or her duties can be affected when the member is experiencing problems in living. FSC clinical counseling services encompass a wide scope of developmental, preventive, and therapeutic services which are designed to address the stressors facing today's military members.

FSC clinical providers offer professional intervention in personal crises and other stressful situations, provide assessment services, assist with problem resolution and, when appropriate, refer to other agencies (both civilian and military). Effective FSC clinical counseling services are skillfully managed and are both reactive and proactive in nature. The reactive part of the FSC clinical counseling services involves responding to direct client inquiries via phone or on a one-on-one basis. The reactive aspect of FSC clinical counseling services must be characterized by:

- A genuine commitment to help.
- Comprehensive intake and assessment services.
- Detailed treatment planning.
- Tracking of all client inquiries and contacts.

- Extensive knowledge of community resources.
- Thorough follow up to ensure matching of client needs to appropriate services.

The proactive aspect of managing effective FSC clinical counseling services involves:

- Conducting a needs assessment to design services and programs (groups) to meet the unique needs of each installation's personnel in accordance with Accreditation Quality Standards.
- Tracking and analyzing intake and screening inquiries to
  - Design groups to address identified populations.
  - Develop outreach "fact sheets" of most commonly asked questions.
- Providing feedback to Installation Commanding Officer and Regional Coordinator (where applicable) regarding the needs of his or her personnel.
- Networking within the Navy and surrounding civilian community to make appropriate referrals and coordinate services.
- Marketing of FSC counseling services by clinical providers and other FSC staff (for example, through the Command Representative Program).

1.3 GOALS OF FSC CLINICAL COUNSELING SERVICES

A major goal of FSC clinical counseling services is to strengthen individuals by assisting them in the problem-solving process. Clinical counseling services enable clients to emerge from periods of stress with increased competence and confidence in their abilities to handle Navy lifestyle stressors such as deployment, relocation, and work schedules. Additional goals of FSC clinical counseling services are to:

- Develop and implement educational programs, clinical counseling services, and groups which assist Navy personnel to adjust to the military lifestyle and to maximize the opportunities the military has to offer.
- Ensure personal and family issues do not detract from operational readiness.
- Raise awareness of the FSC and all of its programs and services available.

1.4 RELATION TO NAVY'S MISSION

FSC clinical counseling services support the mission of the Navy by having a positive impact on three major areas:

OPERATIONAL SUPPORT

- Enhancing personal self-esteem and strengthening individual coping skills can lead to improved job performance.
- Preventing or alleviating stressors allows service members to focus on Navy duties.

RETENTION

- Helping service members cope more effectively with adjustment problems to the Navy and other work-related stressors contributes to the retention of highly skilled personnel in the Navy.
- Helping family members cope more effectively with the stressors related to the military lifestyle which can strongly influence the service member's decision to stay in or get out of the Navy.

QUALITY OF LIFE

- Providing clinical counseling services in FSCs supports the Navy's philosophy of "taking care of its own."

1.5 POLICY AND OTHER GUIDANCE

The following Navy instructions and directives provide policy and guidance to assist FSC clinical providers:

- **SECNAVINST 1754.1A,** Department of the Navy Family Service Center Program: Revises and updates Department of the Navy policy and assigns responsibility for establishing and operating Family Service Centers.
- **SECNAVINST 1752.3A,** Family Advocacy Program: Establishes the Department of the Navy (DoN) policy on Family Advocacy and assigns responsibility for the Family Advocacy Program (FAP).
- **SECNAVINST 1754.7,** Credentials Review and Clinical Privileging of Clinical

Practioners (Providers in Department of the Navy (DoN) Family Service Centers).

- **OPNAVINST 1754.1,** Family Service Center Program: Establishes Navy policy and assigns responsibilities for the administration and support of the Navy Family Service Center Program.
- **OPNAVINST 1752.2A,** Family Advocacy Program: Provides policy and program guidance for the Family Advocacy Program (FAP).
- **OPNAVINST 1752.1,** Sexual Assault Victim Intervention (SAVI): Assigns responsibility for the implementation of SAVI program within the U. S. Navy.
- **NMPC 1754 Serl56/A704 11 May 1989,** Guidance Memorandum—Family Service Center Staff Training, Confidentiality and Referral Procedures: Outlines roles and responsibilities of FSC leadership and staff in staff training, and amplifies existing guidance with regard to the limits of confidentiality and client referral procedures.
- **NMPC 1754 Ser N66,** Risk Management Practices for Family Service Center Staff: Provides guidance for Director on maintaining high standards and professionalism of clinical counseling staff.
- **Accreditation Quality Standards, 1999, Navy Personnel Command (PERS-660)**
- **Navy Quality of Life (QOL) Family Service Center Master Plan of 17 Apr 1998,** A framework for establishing equity of QOL programs and services across the Department of the Navy.

1.6 RELATIONSHIP TO OTHER FSC PROGRAMS

Clinical counseling is an integral part of the FSC system. It supports the mission of the FSC by providing intake, assessment and referral services, short-term individual, marital, and family counseling, group counseling, and psychoeducational support groups which enhance the well-being of Navy service members and families. As illustrated in the FSC Master Plan (Refer to Section 1.6.2), FSCs implement four Readiness Support Capabilities:

- Capability 1 – Operational Support
- Capability 2 – Mobility Support
- Capability 3 – Clinical counseling and Advocacy Support
- Capability 4 – Management and Technology Support

The emphasis given to functions and services within each FSC readiness support capability will vary depending on the mission and demographics of the local installation as well as on identified client needs. Another facet of FSC operations consists of linkage with external service providers. These linkages are a vital part of the network of resources which support clients' needs and the FSC's program structure. To the extent possible, FSCs coordinate delivery of services through these external resources. Inherent in the philosophy of FSC clinical counseling services is that no FSC can or ought to function apart from the community in which it resides or apart from the community of the people it serves. OPNAVINST 1754.1A, FSC Program states:

It is the intent of the FSC program that Centers will not duplicate existing resources of good quality that are otherwise available to Navy personnel and their families. The FSC staff will establish and maintain a close cooperative relationship with existing community (military and civilian) resources.

The clinical counseling staff at a FSC regularly interfaces with the other FSC support capabilities to meet the varying needs of clients. The way in which these capabilities mesh together is dependent on the individual needs of each client. The following example illustrates the interrelationships of the FSC capabilities and external resources.

1.6.1 FSC CASE EXAMPLE

A FSC staff member presents an overview of the scope of services offered through the FSC at a General Military Training (GMT) on board a ship. A service member has been under a tremendous amount of stress which is affecting his work performance and family relationship. He decides to make an appointment with a FSC clinical counselor after participating in the GMT.

The FSC clinical counselor:

- Provides an initial assessment of the service member's personal situation and makes recommendations.
- Refers the service member back through the command to his Command Financial Specialist (CFS) because much of the stress he is experiencing is due to severe financial problems. The CFS (who was trained by FSC Personal Financial Management (PFM) staff) provides one-on-one financial counseling to the service member.
- Refers the service member to a workshop presented by FSC PFM staff on household budgeting/financial planning.
- Refers the service member to a local consumer credit counseling organization for help in negotiating with creditors.
- Offers the service member and his wife couple's counseling at the FSC or refers the couple to a TRICARE (formerly CHAMPUS) approved community mental health provider (depending on local FSC policies) to resolve the relational problems caused by the financial difficulties.
- Refers the service member and his wife to a parenting class designed for step-families to enable the parents to deal more effectively with his two teenage sons from his first marriage since the couple has been arguing about disciplining his sons.
- Provides information to the service member and his wife about the upcoming predeployment programs for adults and children. The ship is scheduled to leave for a 6-month deployment in 8 weeks, and the service member's wife has not been through a deployment and does not know what to expect. The couple's disagreements have centered on the husband leaving for deployment.
- Provides information to the service member and his wife about the Ombudsman Program and the command's family support group so she will have a designated point of contact during the upcoming deployment if she needs assistance.
- Refers the service member's spouse to the Spouse Employment Assistance Program (SEAP), which will assist her in getting a job to help alleviate some of the family's financial problems.

1.6.2 NAVY FAMILY SERVICE CENTER MASTER PLAN

NAVY FAMILY SERVICE CENTER MASTER PLAN
FSC READINESS SUPPORT AND KEY FUNCTIONS

Capability 1: Operational Support Crisis Response Deployment Support Information and Referral Services Life Skills Education Ombudsman Support Outreach Services Personal Financial Management Sexual Assault Victim Intervention Program	**Capability 3: Counseling and Advocacy Support** Clinical Counseling New Parent Support Program Family Advocacy Victim Advocacy
Capability 2: Mobility Support Exceptional Family Member Support Relocation Assistance Spouse Employment Assistance Transition Assistance Intercultural Relations Program for OCONUS FSC	**Capability 4: Management and Technology Support** FSC Management Administrative Support Computer Support Distance Education Marketing and Community Partnerships Military Facilities Support Management Volunteer/Retiree Coordination

1.7 COORDINATION WITH COMMUNITY RESOURCE PROVIDERS

FSC clinical providers are in a position to educate the civilian community about the Navy. A clinical provider's job entails linking clients with appropriate resources because FSC policy guidelines specifically state FSC staff should not duplicate already existing resources. There should be a cooperative relationship between FSC clinical providers and practitioners and agencies in the community. The more FSC clinical providers know about the resources available in the community, the better they will be able to meet the needs of the clients who come to the FSC for assistance. The FSC counselor generally employs a systems approach when intervening with clients to develop a comprehensive treatment plan which includes using available resources. These resources can include community medical facilities; mental health providers (either agencies or private practitioners); family service agencies; financial counseling providers; multiservice agencies such as the YMCA and American Red Cross; and a host of other services available in local communities worldwide. It is the responsibility of the FSC clinical provider to not only be aware of referral sources for clinical counseling services but also to work closely with the FSC Information and Referral Specialist to become acquainted with the wide range of other supportive services available to military families in their local community.

1.8 COORDINATION WITH OTHER NAVY RESOURCES

In addition to the resources available within the FSC system and throughout the local community, FSC clinical counseling staff also have access to other resources provided by the Navy. Below is a list of resources in the Navy community that FSC clinical providers use for referrals and that also refer to the FSC. Developing and maintaining close, cooperative relationships with these resources and agencies is an important task for each FSC clinical provider.

- **SUBSTANCE ABUSE**

  The Drug and Alcohol Program Advisor (DAPA) is an individual at each command who is tasked with the responsibility of assessing and appropriately referring individuals who may have issues with alcohol and drug abuse/misuse. The command DAPA's responsibilities are generally a collateral duty and skills, and the abilities of the DAPA may vary from command to command.

  In 1996, the Alcohol Rehabilitation Centers were realigned under BUMED and became the Alcohol Rehabilitation Department (ARD). There are five levels of

treatment that include early intervention services, outpatient treatment services, intensive outpatient treatment program, residential treatment and medically managed treatment program.

- **SPOUSE AND CHILD ABUSE**

  Family Advocacy Program (FAP):

  The Navy's FAP addresses the prevention, identification, evaluation, intervention, treatment, follow-up and reporting procedures of:

  - Child physical abuse.
  - Child emotional abuse and neglect.
  - Child sexual abuse (intra/extra familial).
  - Spouse abuse.

Refer to Part 6 of this *Desk Guide* or the *FAP Desk Guide* for further guidance.

- **PSYCHIATRIC EVALUATIONS**

  Psychiatric evaluation of active duty members are conducted at the local Military Treatment Facility (MTF) by privileged psychiatrists or psychologists. These evaluations are conducted on either an outpatient or inpatient basis and may determine whether the service member is fit or suitable for continued military service. Service members who are not fit for full duty are either referred for medical discharge or placed on limited duty. Those who are not suitable for continued military service are subject to administrative processing. Psychiatric evaluation is also utilized to determine whether inpatient or outpatient admission to psychiatric care is indicated. Active duty members who present with problems that fall outside the scope of care offered in the FSC should be referred to the local MTF for further evaluation, treatment and referral, as appropriate. Consult your local MTF on the procedures for emergent, urgent and routine referral of active duty members for psychiatric evaluation.

  Family members who are in need of psychiatric evaluation and/or treatment should be referred to their primary health care provider. Consult your local health benefits advisor for regional procedures regarding mental health referrals. TRICARE referrals sources should be advised whether the referral is emergent, urgent or routine.

- **CHAPLAINS**

  Chaplains can provide pastoral counseling, prevention programs, and family enrichment programs to service members and their families. In addition, they can provide guidance to FSC Directors and staff concerning moral, religious, and spiritual issues as it relates to service member's readiness.

- **LEGAL INFORMATION**

  Navy Legal Services Office (NLSO)

  The NLSO can offer no-cost consultations and services on a wide range of legal issues (e.g., wills, powers of attorney, separation, divorce, abuse, non-support, etc.) on a space available basis. Consultations are generally on a one-time basis and a referral is provided to the local bar association for a local attorney. NLSO cannot provide an attorney to represent individuals in civilian court.

- **FINANCIAL AND EMERGENCY ASSISTANCE**

  Navy-Marine Corps Relief Society (NMCRS)

  The NMRS provides emergency loans or grants for food, shelter, clothing, or emergency transportation. Most installations have a NMRS, staffed primarily by volunteers, who can offer these services. Additional services may include one-on-one financial counseling, student loans, dental and medical care loans, emergency transportation for illness or death of a family member, and/or visiting nurse services.

- **AMERICAN RED CROSS (ARC)**

  The ARC assists military families with emergency funding, shelter, or food, as well as supports requests for emergency leave by sending verified emergency information to the service member's command.

- **EMERGENCIES AND CRISIS INTERVENTION ASSISTANCE**

  Command Duty Officer (CDO)

  The CDO is available 24 hours a day as a point of contact (POC) for emergency assistance for either FSC clinical providers or families needing emergency after-hours assistance. The CDO can be contacted through the command or installation quarterdeck.

  Base Security Police

  Military and civilian personnel comprise the Base Security Police Forces at Naval installations worldwide and are responsible for the public safety of that installation.

  Naval Criminal Investigative Service (NCIS)

  The NCIS is responsible for the investigation of active duty members and family members under federal jurisdiction who are involved in allegations of felonious criminal behavior.

1.9 SCOPE OF FSC CLINICAL COUNSELING SERVICES

1.9.1 ELIGIBILITY FOR SERVICES

According to SECNAVINST 1754.1A, Department of the Navy Family Service Center Program (February 1999):

The primary mission of each FSC is to assist commands in achieving operational, readiness, superior performance, member retention, and a reasonable quality of life for Department of the Navy personnel and their families.

The following personnel are eligible for FSC services, subject to any restrictions in status of force agreements (SOFA) at overseas activities:

a. Active duty members of the Military Services and Coast Guard and their legal dependents.
b. Members of the Reserve Component of the military services and the Coast Guard, and their legal dependents, while on a call or order to active duty.
c. Spouses and legal dependents of prisoners of war or personnel missing in action (POW/MIA) from the military services and the Coast Guard.
d. Nonforeign hire civilian employees of the Department of Defense (DoD) in overseas locations, and their legal dependents, for services which are not otherwise available in the local community.
e. On a space available basis, retired members of the military services and Coast Guard, their legal dependents, and the dependents of members who were on active duty or retired at the time of death.

1.9.2 TYPES OF PROBLEMS ADDRESSED

As per SECNAVINST 1754.1A, FSC clinical counseling services are tasked with addressing specific kinds of problems.

"Services are provided to individuals, couples or families to monitor or treat mental health-related problems. Such services include assessment, diagnosis and treatment planning, as well as the initiation, alteration or termination of a course of clinical care. During intake or delivery of counseling services, if it is determined that clients have organic impairment, a diagnosable mental illness or psychological dysfunction, or long-term counseling needs, appropriate referrals shall be made."

The intent is to limit clinical counseling to defined problem areas rather than to overall personality change; specifically, to address situational "problems-in-living" (e.g., academic, occupational, parent-child, marital, or intrafamilial violence problems) rather than "personality disorders" or "mental disorders" (e.g., chronic depression, schizophrenia, or organic impairment). Generally, the conditions listed as V Codes in the *DSM-IV* are appropriate for FSC clinical counseling interventions.

FSCs located outside of the continental United States (OCONUS) and some FSCs located in isolated geographical areas inside the continental United States (CONUS) may have limited access to approved TRICARE providers. These FSCs may be the only available provider of clinical counseling services and may need to expand the scope of service provision. Some FSCs OCONUS may find that even when there are TRICARE providers in the civilian community, clients may not feel comfortable using these providers because of cultural and language barriers. Though the focus of most clinical counseling interventions should be directed toward clients who have conditions listed as V codes in the *DSM-IV*, FSCs operating in OCONUS or in isolated areas are more likely to provide clinical counseling services to some clients with conditions that fall outside of this category. Refer to Section 4.4, Diagnosing with the *DSM IV* for further guidance.

1.9.3 LENGTH OF SERVICE DELIVERY

The primary focus of FSC clinical counseling services is the provision of "clinical counseling services intended to be problem-focused and brief." Clinical counseling services offered by FSCs meet a basic need for outpatient supportive counseling, which is focused on well-defined problem areas and helps to reduce the costs associated with referrals to private social service providers. Group counseling and facilitation of support groups is encouraged. As Guidance Memorandum: Family Service Center Staff Training, Confidentiality and Referral Procedures, 11 May 1989 states:

"Short-term" clinical counseling is not specifically defined in terms of number of sessions since availability of outside resources, circumstances of specific cases, and FSC staff capability should be allowed to drive the interpretation of "short-term" at each FSC under management administrative control. Ultimately, this is the decision of the FSC Director in consultation with the staff and the Commanding Officer.

Exceptions to this directive of providing short-term clinical counseling are as follows:

- Clinical providers are allowed to carry a small caseload for whom an "extension of services" has been granted. The type of cases acceptable for an extension of services include but are not limited to dual career military and active duty members who are ineligible for TRICARE, and those facing a Navy specific life event (i.e., preparing for deployment or coping with geographic separations).
- FSCs located overseas (OCONUS) and some FSCs located in isolated geographical areas in CONUS may have limited access to approved TRICARE providers in the civilian community. Because these FSCs are often responsible for providing clinical counseling services for all eligible clients, they are more likely to see clients for a greater number of clinical counseling sessions than FSCs who have access to an adequate number of TRICARE providers in the civilian community.
- Family Advocacy Program (FAP) related counseling remains problem focused, although it may extend beyond the typical number of sessions offered in an FSC. It is generally recognized that child and spouse abuse are complicated problems that may require more than a few sessions for successful outcomes. In addition, some civilian jurisdictions have treatment length mandates for court-ordered individuals (e.g., court-ordered spouse abusers). While nothing in current Navy policy requires an FSC to comply with local requirements regarding treatment parameters including length, FSCs providing state-approved treatment for adjudicated active duty or family members are required to comply with local requirements.

In summary, it is the responsibility of each FSC to determine the parameters of short-term clinical counseling. In general, the following factors should be taken into consideration when determining the length of service delivery:

- Nature and intensity of the client's problem
- Expected length of treatment
- Caseload demands of the clinical counseling staff
- Size of the waiting list and average length of time clients must wait to get a counseling appointment
- Availability of resources in the civilian community
- Availability of other Navy resources

PART TWO: Confidentiality

2.1 FSC STANDARDS OF CONFIDENTIALITY

SECNAVINST 1754.1A, Department of the Navy Family Service Center program, states:

Many of the individual and family problems revealed when eligible personnel seek assistance from the FSC are intensely personal, and in some cases, can place social acceptance, professional standing, and career progression of service members at risk. For this reason, information concerning individuals seeking service from the FSC must be treated with the highest degree of confidentiality. All FSC personnel must ensure careful and sensitive handling of case information. All records, except statistical records where individual identity cannot be determined, shall be maintained and protected within the rules of the Privacy Act in FSC or Family Advocacy Program (FAP) records management systems and this instruction.

To protect the individual's rights and to establish and maintain credibility within the Navy community, it is imperative that the strictest standards of confidentiality be adhered to with regard to clients who are seeking counseling services. FSC Accreditation Quality Standards specifically address confidentiality issues which are identified in Part 5 of the *Clinical Counseling Desk Guide*. Some of the internal controls FSCs can implement to create an environment which fosters client confidentiality include the following:

Waiting Area

The creation of a waiting area for counseling clients which is separate from the main FSC reception area will minimize the opportunity that clients will meet someone they know while waiting for their appointment. A separate waiting area gives some privacy to clients who are emotionally upset. FSCs often lack enough space, but creative use of office space and the use of portable trailers in some FSCs have helped achieve this goal.

Clinical Counseling Offices

Accreditation Quality Standards specify the local FSC must make every effort to ensure that clinical counseling rooms are soundproof and private. One solution to this problem is to install white noise machines outside the clinical provider's office, which not only protects the confidentiality of clients but enables other FSC staff to carry out their duties without being distracted by conversations in adjoining offices.

Client Case Record Files

Clinical counseling files must be safe guarded at all times. At the close of daily business or when staff members are out of the building, all case materials should be cleared from desktops and routing boxes. Case materials, such as face sheets, documents which contain identifiable client information, inquiry and referral sheets, recording summaries, and other correspondence should be kept in locked file drawers. All records must be maintained in a "double locked" method with both the file drawers locked and external office doors locked at the end of the day. Only authorized staff members should handle case materials. Refer to Part 3, Administrative Case Record Management, for more information on this topic.

All FSC staff, volunteers, Limited Duty (LIMDU), and Temporarily Assigned Duty (TAD) personnel who are working at the FSC should go through an orientation process explaining the sensitive nature of FSC business and outlining the strict confidentiality guidelines they will be expected to follow while they are assigned to the FSC. These guidelines will be spelled out very clearly. Every effort should be made to see that personnel temporarily assigned to FSCs have limited access to confidential information. Volunteers, with the exception of supervised student clinical counseling interns, may **NOT** have access to confidential client information.

2.2 CONFIDENTIALITY REQUIREMENTS

Confidentiality of records and information on FSC clients is critical to the professional credibility of FSC Clinical Counseling Services. FSC client records are established, protected, maintained, and eventually destroyed under the cognizance of:

- **SECNAVINST 5211.5D Series (Privacy Act).**
- **OPNAVINST 1754.1 Series, (Family Support Program).**
- **SECNAVINST 1752.3A (Family Advocacy Program).**

- **SECNAVINST 5720.42 Series (Freedom of Information Act).**
- **Federal Register, Volume 64, No. 81, Systems Notice, April 28, 1999.**
- **April 28, 1999, 64 FR 22842, Family Advocacy Program System (N01752-1)**
- **April 28, 1999, 64 FR 22845, Navy Family Support Clinical Counseling Records (N01754-1)**

Please note that changes to Federal Systems Notices occur with some frequency. Staff with administrative responsibility for case records should periodically consult with PERS-661 to insure that they have the most current systems notice.

Pertinent instructions that all FSC clinical providers should be cognizant of are highlighted in Section 1.5 and below:

- **PRIVACY ACT OF 1974, 5 U.S.C. SECT. 552a:** Provides guidelines for the **disclosure of information about clients** by (a) limiting access to personal information contained in record systems and (b) mandating certain management safeguards for such records.
- **SECNAVINST 5211.5D, 1992, DoN Privacy Act (PA) Program:** Implements the Privacy Act in the Navy. FSC client records will be maintained in strict compliance with the Privacy Act and **SECNAVINST 5211.5D.**
- **FREEDOM OF INFORMATION ACT (FOIA):** Provides guidelines for handling requests for access to clients' records.
- **SECNAVINST 5720.42D,** Department of the Navy Freedom of Information Act (FOIA) Program: Implements the FOIA in the Navy. The Privacy Act and the FOIA interface to protect the confidentiality of clients seeking counseling services at FSC.
- **NMPC 1754 Ser 156/A704, 11 May 1989, Guidance Memorandum for FSC Directors:** Provides detailed guidance on client records requests.

Any member/employee of the Department of the Navy may be found guilty of a misdemeanor and fined up to $5,000 for willfully disclosing information protected by the Privacy Act to any unauthorized person or agency. Note that FSC volunteers are not members or employees of the Department of Defense for purposes of the Privacy Act, and consequently volunteers may not see a clinical client's case records.

2.2.1 COMPUTERIZED DATA CONFIDENTIALITY ISSUES

With increasing computerization of counseling information within the FSCs, clinical providers need to be aware of security measures associated with computer usage. Before loading any client data onto the computer the counselor must have basic computer training. It is the responsibility of the FSC to formulate and implement a local policy with respect to the information being stored on automated systems.

Components of policy should address the following:

Purpose. Policy normally includes a statement describing why the program is being established. This may include defining the *goals* of the program. Security-related needs, such as integrity, availability, and confidentiality, can form the basis of organizational goals established in policy. For instance, in an organization responsible for maintaining confidential personal data, however, goals might emphasize stronger protection against unauthorized disclosure.

Scope. Policy should be clear as to which resources—including facilities, hardware and software, information, and personnel—the computer security program covers. In many cases the program will encompass all systems and organizational personnel, but this is not always true. In some instances it may be appropriate for an organization's computer security program to be more limited in scope.

Responsibilities. Once the computer security program is established, its management must be assigned to a staff member who has the skills and abilities to oversee the program.

Specific Security Issues. Program must assess password control and administration, data backup and storage, physical security of data storage devices, Internet access and prevention of unauthorized access (firewalls), and data record destruction (case closing).

2.3 APPLICATION TO FSC CLINICAL COUNSELING CLIENTS: PRIVACY ACT STATEMENT

Before collection of any information from a FSC client, the client must be provided a Privacy Act Statement. All FSCs will use the Privacy Act Statement included in SECNAVINST 5211.5D. This statement will be part of all FSC forms which collect information from a client (Refer to Attachment 1).

Client records are opened when the clinical staff member who intends to provide or

initiate requested services has the client sign the Privacy Act Statement at the beginning of the interview. FSC clinical providers should be sure each client is aware of all the exceptions to confidentiality in the military and the client is cognizant of reporting requirements. The clinical staff member will witness the signature and fill in the date. Clients who decline to sign the statement will be denied clinical counseling services (if they are not presenting in an emergency situation). Clinical providers can use their knowledge of community resources to provide an appropriate referral to any service member or family member who declines services through the FSC.

For couples requesting marital counseling, a separate Privacy Act Statement must be reviewed and signed by each client **(separate case records are opened for the service member and for the spouse)**.

FSC client files will be retained under the name and case number of the client being served. Military sponsor names or other sponsor identifying information will NOT be used to identify files of FSC clients who are family members. Sponsor social security numbers may NOT be used to identify FSC client files. Military sponsors will NOT be granted access to family members' records.

The *Family Advocacy Program (FAP) Desk Guide* outlines the procedures for keeping FAP records when the FSC has case record management duties for FAP records. Refer to the *FAP Desk Guide* for detailed guidance.

2.4 EXCEPTIONS TO CONFIDENTIALITY IN THE MILITARY COMMUNITY

In the military community, service members recognize there is not the same right to privacy which is expected in the civilian community. While adhering to the highest personal and professional standards of conduct, the clinical provider may be in a position to have to disclose pertinent information to a service member's command or to another military resource. The clinical provider's responsibility is to provide the client with the information needed to provide an informed consent for services (reference National Association of Social Workers (NASW) *Code of Ethics 1998*, paragraph 1.07, Privacy and Confidentiality). It is then incumbent upon the service member to decide whether or not to disclose any information.

The Privacy Act allows a FSC to disclose information from a client's record **WITHOUT**

the consent of the client in certain carefully defined cases listed below. Disclosure means a review of the pertinent information contained in the record. It is the clinician's responsibility to provide a thorough explanation of the Privacy Act Statement, including exceptions to confidentiality which allows the client to make an informed decision about what information is shared.

- Disclosure to officers and employees of the Department of Defense (DoD) who have a need for the record in the performance of their duties. For example, this exemption allows a client's records to be disclosed to the following individuals:
  (1) The professional staff of the FSC, but **NOT** to FSC volunteers.
  (2) Commanding Officers and other appropriate DoD authorities, in compliance with BUPERINST 5510.11D, Nuclear Weapon Personnel Reliability Program (PRP), and certain high-level security clearances.
  (3) Commanding Officers and appropriate DoD authorities, in compliance with OPNAVINST 5350.4, Substance Abuse Prevention Control.
  (4) Commanding Officers in cases of alleged spouse abuse, child abuse and neglect.
  (5) DoD law-enforcement activities, for example Naval Criminal Investigative Service, Naval Legal Service Offices, in connection with their official duties.
  (6) Commanding Officers and other appropriate DoD authorities (e.g., DoD medical or security personnel) when the professional FSC clinical provider judges that the client's life is in danger or that other lives and/or significant property is endangered by the client or others.
  (7) Commanding Officer's and appropriate DoD authorities, (e.g., victim advocates, NCIS, medical) in cases of sexual assault in compliance with OPNAVINST 1752.1A (SAVI program).

- Disclosure for a "routine use" of the FSC records. Routine uses are published in the *Federal Register* and are included in the Privacy Act Statement given to FSC clients. Those requesting disclosure pursuant to one of the routine uses listed below must put their request in writing. The following lists four of the more important routine uses:
  (1) Disclosure to state and local government authorities in accordance with state or local laws requiring the reporting of suspected child abuse or neglect. In this case, there is no requirement to put the request for information in writing.
  (2) Disclosure to the appropriate federal, state, local, or foreign agency charged

with law enforcement, where FSC records indicate that a violation of law may have occurred.

(3) Disclosure to certain foreign authorities in connection with international agreements, including status of forces agreements (SOFAs).

(4) Disclosure to the Department of Justice for litigation purposes.

In cases where there is any question as to the propriety of disclosure, the advice of a staff judge advocate general (JAG) should be sought.

The Record of Disclosure Form (Refer to Attachment 2) should be added to case records upon recordable release. It should be physically affixed to the record from which the information is disclosed. The primary criteria are that the selected method be one which will:

(1) enable an individual to ascertain what persons and agencies have received disclosures pertaining to him/her,

(2) provide a basis for informing recipients of subsequent amendments or statements of dispute concerning the record, and

(3) provide a means to prove, if necessary, that the activity has complied with the requirements of the Privacy Act of 1982.

The disclosure accounting is maintained for the life of the record to which the disclosure pertains, or for at least 5 years after the date for which the accounting is made, whichever is longer. There is no instruction which requires retaining the disclosed record itself longer than for the period of time provided for it in SECNAVINST 5212.5D, Disposal of Navy and Marine Corps records, but the disclosure accounting must be retained for a period of 5 years.

2.5 REPORTING PROCEDURES FOR EXCEPTIONS TO CONFIDENTIALITY

Staff disclosures to appropriate civilian or military authorities in situations where there are exceptions to confidentiality should always be discussed with the Clinical Supervisor before disclosure is made. In the absence of the Clinical Supervisor, the FSC Director should be consulted. These consultations should be noted in the case record. The following procedural guidelines should be used when reporting exceptions to confidentiality.

2.5.1 PERSONNEL RELIABILITY PROGRAM (PRP)

Personnel who are in the Personnel Reliability Program (PRP) and seeking clinical counseling at a FSC must sign the FSC "Privacy Act Statement for Service Members Governed by Nuclear Weapons Personnel Reliability Program" (Refer to Attachment 3). Persons in this program should understand they have surrendered some privacy in exchange for the PRP certification. Conditions which can lead to the decertification from the PRP are listed here:

(1) Alcohol abuse

(2) Drug abuse

(3) Poor performance of duty

(4) Serious legal problems (including serious financial difficulties)

(5) Significant personal difficulties

(6) Unacceptable traits (as substantiated by medical authority)

(7) Poor attitude or motivation

(8) Homosexuality or deviant behavior

When it is necessary to question the current reliability of a member, the procedure is to:

- Promptly discuss the situation with the Clinical Supervisor.
- If the reliability concern is confirmed by this discussion, the Clinical Supervisor should inform the FSC Director.
- The assigned staff member or the FSC Director should then call the individual's command to describe the relevant aspects of the situation.
- If the individual was referred by the command, the referring individual will be called, and a form letter will be sent to the Commanding Officer by the FSC Director (Refer to Attachment 4).
- If the individual was **NOT** command referred, the individual's Executive Officer will be called, followed by a pro forma Commanding Officer letter (Refer to Attachment 4).
- The Officer in Charge of a reserve unit will be called.
- In **ALL** instances, the FSC Director will be informed by memo.

2.5.2 ALCOHOL AND DRUG ABUSE

FSC clinical providers are presented with a variety of casework situations in which alcohol and/or chemical dependency issues are present. Clinical providers must possess the skills to perform an initial chemical dependency screening, follow the necessary reporting requirements, and have a strong working knowledge of the military and civilian resources available to treat alcohol and drug abuse.

Reporting Criteria

- FSC clinical providers are **required** to report any known or suspected current illegal or nonmedical use or possession of drugs.
- Alcohol abuse should be reported when it appears to impact service members' ability to do their jobs.
- Reports should be made directly to the service members' immediate supervisor or Commanding Officer. If there is a risk of imminent harm due to the service member's impairment and neither of these individuals is available, the base police, Quarter Deck, or NCIS may be contacted.
- The above applies to self-admission by the service member. If the report is made regarding the service member by an outside source (e.g., spouse), the service member may be offered the option to come in for an interview or be referred to appropriate resources.

2.5.3 FAMILY ADVOCACY PROGRAM (REFER TO PART 6)

Allegations of family violence (i.e., child or spouse abuse) are managed by the Navy's Family Advocacy Program (FAP). See Part 6 and the Family Advocacy Program Desk Guide for a more detailed discussion of these issues. The FAP is a line-managed program which may be physically located within the FSC, in an MTF, or in a free-standing FAP Center. Regardless of the physical location of FAP staff, each FSC should develop a written protocol detailing how mandatory reporting requirements are accomplished when family violence is suspected (e.g., who is responsible for making reports to civilian agencies) and how services are coordinated between FSC clinical counseling and FAP staff.

2.5.3.1 CHILD ABUSE/NEGLECT

Clients are informed of the mandatory reporting requirements when signing the Privacy Act, in the event that suspected child abuse is disclosed within the context of counseling.

Current Navy policy (OPNAVINST 1754.2A) states that any known or suspected incident of child abuse occurring on a military installation or involving persons eligible for FAP services must be reported to the local Family Advocacy Representative (FAR). Child abuse includes emotional, physical and sexual abuse, as well as neglect.

When an incident of suspected child abuse involving a military medical beneficiary (i.e., active duty member, family member of an active duty member, or Department of Defense (DOD) employee overseas) is disclosed during clinical counseling, the clinical provider is required to report this to the FAR. The procedures for making a report to FAP are detailed in Part 6.

Current Navy policy requires the FAR to notify:

- the member's command, depending upon the results of an initial assessment,
- the state or civilian agency having child protective service function (hereafter referred to as Child Protective Services (CPS)), consistent with applicable laws and Memorandum of Understanding,
- local authorities in overseas installations, in accordance with applicable treaties and Status of Forces Agreements (SOFA),
- the appropriate law enforcement/security department personnel if there is major physical injury or indication of an intent to inflict major physical injury, and
- Naval Criminal Investigative Service (NCIS) in the case of child sexual abuse or other felony level family violence, and Navy Personnel Command (PERS-661) in cases of suspected child sexual abuse. More immediate reporting requirements apply in instances of alleged child sexual abuse in DOD sanctioned out-of-home child care settings.

In the absence of a FAR, incidents of known or suspected child abuse are reported directly to CPS and to law enforcement/security if there is imminent danger to the child.

In cases where suspected child abuse is uncovered during counseling with clients who are not eligible for military medical care (e.g., retirees or their family members), the

FAR may be consulted to provide guidance and the clinical provider must report to CPS. Reports to CPS should be made within 24 hours.

Specific procedures and requirements for reporting vary from one CPS agency to another. **It is recommended that the FSC incorporate a copy of all local and state laws and any applicable MOU regarding suspected child abuse/neglect into its written family violence protocol.**

When reporting to CPS, be prepared to provide the following information:

- name, social security number, and address of the child and guardian/parent,
- child's age and sex,
- description of alleged abuse/neglect,
- name of others, particularly children, living in the home.

NOTE: Regardless of whether a case of suspected child abuse is referred to FAP or the civilian CPS agency for assessment and management, the FSC clinical provider remains responsible for the case and for safety concerns until FAP or CPS assumes responsibility. In other words, an FSC clinical provider should **always** conduct a safety assessment and safety planning whenever suspected child abuse is disclosed within the context of counseling. Recommended procedures for completing safety assessment and safety planning are outlined in Part 6.

2.5.3.2 SPOUSE ABUSE

Spouse abuse is the most frequently reported type of family violence in the Navy and frequently co-exists with child abuse. Whenever a FSC clinical provider becomes aware of spouse abuse, for example, they should always inquire about possible child abuse and vice versa. However, when inquiring about possible family violence, **NEVER** question family members together because it may inhibit their ability to provide information freely or expose them to greater danger. Violence between unmarried intimate partners for whom there is an ongoing relationship pattern is also assessed and managed by the FAP, per current Navy policy. Intimate partner abuse will, hereafter, be referred to as spouse abuse.

Civilian jurisdictions vary with regard to the reporting of intimate partner abuse. **Therefore, it is recommended that the FSC insert a copy of all local and state**

laws which apply to reporting of intimate partner abuse in its written family violence protocol.

Current Navy policy (OPNAVINST 1754.2A) allows more latitude (than in the case of child abuse) when reporting spouse abuse to FAP and a member's command. Possible scenarios are outlined below.

If a **VICTIM** of alleged spouse abuse comes voluntarily to the FSC seeking counseling, the clinical provider is NOT required to report the incident if:

- there are no current injuries, and
- the victim is responsive and capable of responding to any renewed threat, and
- previous abuse did not result in "major physical injury," as defined in OPNAVINST 1752.2A, and
- safety assessment does not indicate immediate danger, and
- safety planning has been done, and
- the victim does not want it reported.

If **ALL** of the above are true, the FAR and the clinical supervisor (in the case of non-privileged clinical providers) should be consulted before it is decided the suspected spouse abuse will not be reported. When consulting with the FAR, the identity of the couple should be disclosed to the FAR, after you clarify you are requesting consultation and not reporting; the FAR may be aware of previous instances of abuse between these parties which have not been disclosed to you.

Whenever a decision is made **NOT** to report spouse abuse, the case notes should clearly reflect the results of risk/safety assessment and safety planning, the results of consultation, and the rationale for not reporting to FAP.

If at any time while working with the victim, the clinical provider determines the victim is in imminent danger, the clinical provider must report the situation to the FAR and the service member's command and take necessary steps to promote the victim's safety.

If a victim of spouse abuse comes voluntarily to the FSC and there **ARE** current injuries:

- refer the client to the appropriate MTF for treatment, and

- notify the FAR and law enforcement personnel.

If an **OFFENDER** of spouse abuse present voluntarily to the FSC seeking counseling:

- gather information to complete the incident report (from the Navy Risk Assessment Model) and to assess for the immediate safety of the victim, and
- make a report to FAP.

Current Navy policy provides no specific guidance on reporting requirements when a couple comes voluntarily to an FSC for assistance with spouse abuse. If they present at initial screening with this problem, they should be referred directly to FAP. If they disclose such a history within the context of already initiated clinical counseling, best practice suggests that the clinical provider should:

- see the individuals separately to thoroughly assess the history of violence,
- complete safety assessment and safety planning with the victim,
- assess whether the issues pertaining to not reporting when victims present voluntarily are applicable, and
- consult with the FAR and the clinical supervisor (in the case of non-privileged providers) or Chief of Clinical Services on whether or not a report should be made to FAP.

Couples counseling within the context of spouse abuse can be useful for a very small percentage of couples and in very limited situations but should be used very judiciously and only after thorough, careful assessment of the individuals and the violence history. In most cases, couples counseling should occur after thorough assessment, review by the CRC, and CRC recommendation for couples counseling, with continual monitoring by the FAP/CRC during the couples counseling. In any case, the FSC clinical provider who is conducting couples counseling when a history of family violence is revealed should very carefully document the assessment and decision process regarding reporting to FAP.

NOTE: As with child abuse, the FSC clinical provider remains responsible for the case and for safety concerns until FAP or civilian agencies assume responsibility. Communication and coordination of efforts with FAP staff are critical, regardless of where FAP staff are located.

2.5.4 SUICIDE

FSC clinical providers are presented with a wide variety of situations, which include the threat of loss of life by suicide. All FSC staff (not just clinical providers) should have up-to-date knowledge of the reporting systems and procedures followed in the event a FSC client with suicidal intent presents at the FSC or calls the FSC for assistance. Every FSC should have a written Standard Operating Procedure (SOP) for handling suicidal clients.

Privacy Act restrictions do not apply in cases of suicide/life-threatening, self-destructive behavior. Clients are informed of the reporting requirements in the event that in working directly with a client, the FSC clinical provider assesses that the client's life is in danger (i.e., client may do harm to himself or herself). This is stated in the Privacy Act Statement clients sign prior to the initiation of clinical counseling.

2.5.4.1 DEFINITIONS

SUICIDAL: Describes a person expressing suicidal ideas, thinking of suicide, contemplating suicide, or any person manifesting self-destructive behavior of a life threatening nature.

SUICIDE: The completion of an act to take one's own life, regardless of the method used.

Refer to Part 7, Crisis Intervention, for assessment, referral procedures, and treatment options for suicidal clients.

2.5.4.2 REPORTING REQUIREMENTS FOR ACTIVE DUTY CLIENTS

- As previously stated, the service member's command must be notified immediately after the FSC clinical provider has assessed that the client may be a significant danger to him or herself.
- Information given to the command must provide a statement about the suicide risk, a plan of intervention, and a plan for follow-up. Specific details regarding the personal problems related to the suicidal thinking should be limited to provide some privacy for the individual. The clinical provider should use his or her clinical judgement in determining the extent of information given to the command, which will vary on a case-by-case basis.

2.5.4.3 PHONE CALLS FROM COMMANDS

- Commands may call FSC requesting consultation and assistance regarding a service member with suicidal intentions. A release of information does not need to be signed by the client if the client's life is in danger.
- If the situation is an emergency (individual is threatening suicide and may have access to the means), the service member should be escorted by the command directly to the base Medical Treatment Facility (MTF) or to the emergency room of a local civilian hospital if a MTF is not available.
- If the situation is not urgent (warning signs are evident but no threat has been made), the clinical provider should request the service member be **escorted** to the FSC for an evaluation.

2.5.5 HOMICIDE

2.5.5.1 DEFINITIONS

HOMICIDAL: The intent to do harm to others, and/or have potential for violent acting out and is inclusive of any person expressing homicidal ideas, thinking of homicide, contemplating homicide, or any person expressing intent to do bodily harm to another of a life-threatening nature.

HOMICIDE: The commission of an act to end another's life, regardless of the method.

Refer to Part 7, Crisis Intervention, for assessment of homicidal clients and referral procedures.

2.5.5.2 REPORTING REQUIREMENTS FOR ACTIVE DUTY CLIENTS

If a clinical provider in the course of clinical counseling becomes aware of a client's intent to do serious bodily harm to another, he or she is required by law to exercise his or her duty to warn.

When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn

the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever steps are reasonably necessary under the circumstances.

Knappy, S., & Vanete Creek, L. (1982). Tarasoff: Five Years Later. *Professional Psychology, 15*, 511 - 516.

Further implications of the Tarasoff decision are examined in the following references:

- Vancreek, Leon and Knapp, Samual (1993). Tarasoff and Beyond: Legal and Clinical Considerations in the Treatment of Life-Endangering Patients. Practioners Resource Series.
- Calderone, J.M. (1992). The Tarasoff Raid: A New Extension of the Duty to Protect; Bull. American Academy of Psychiatry and the Law.

A FSC clinical provider must notify:

- the intended victim,
- the police in the jurisdictions of the victim/crime,
- base security if the client is active duty,
- the clinical supervisor (if the provider is not privileged) or, if the clinical supervisor is unavailable, the Chief of Clinical Services and/or the FSC Director (Privileged independent practitioners should consult with the Chief of Clinical Services and/or FSC Director, in accordance with local policy and protocols),
- the Command (Privacy Act restrictions do not apply in the case of life-threatening behavior. Commands should be notified as soon as possible.
- Psychiatric staff at the MTF or local hospital with a written evaluation arranged via the command.

Procedures for referring and managing homicidal clients are described in Part 7, Crisis Intervention.

2.6 REPORTING PROCEDURES FOR COMMAND REFERRALS

For command-referred members, *where the situation is not an exception to confidentiality in the military,* the following feedback should be provided to the command per request of the referring individual or the Commanding Officer (as per NMPC1754 Ser156/A704 11 May 1989, Guidance Memorandum). The client should be informed of your intention to share the following prior to signing the Privacy Act Statement:

(1) That the service member was seen at the FSC.
(2) A brief, general assessment of the situation.
(3) Recommendations for intervention and/or referral.
(4) Estimated length of time needed to correct the situation.
(5) Specific recommendations for command action, if applicable.

Information that is directly related to job performance, within the parameters described above, can be shared with the command. Other information that does not adversely affect job performance is confidential. Directions to disclose information to commands only relate to active duty personnel. Civilian spouses and children are protected from command access and mandatory reports to commands.

When the command's primary interest is whether the service member is "fit for duty" those members should be referred to the local MTF for full evaluation. The FSC clinical provider's role is to support command readiness; FSC clinical providers do not conduct official "fit for duty" evaluations.

2.7 REQUESTS FOR ACCESS TO FSC CLINICAL COUNSELING RECORDS

Requests for record access will be handled as follows (Refer to Attachments 5-9 for sample forms):

REQUEST BY CLIENT

A request by a client for access to his or her own record will be handled in accordance with the Privacy Act, SECNAVINST 5211.5D, and Systems Notice, Volume 64, No. 81, April 28, 1999. A written request must be submitted to the commanding officer of the Naval activity from which they were seen for counseling. Upon receipt of the request by the CO, the client will be provided with a copy of the clinical counseling record. If possible, review of the record should occur while a professional clinical staff member is present in case the client has questions and/or concerns about the record. Access does not extend to confidential materials other agencies have provided to FSC. Consultation with the JAG is required when the client is being seen for family violence related problems and is recommended for all requests for access to clinical counseling records.

REQUEST BY THIRD PARTY

A written third party request for access to a client's record made with prior written consent of the client will be handled in accordance with the Privacy Act, SECNAVINST

5211.5D, and Systems Notice, Volume 64, No. 81, April 28, 1999. A Release of Information Authorization form must be signed by the client and included in the client's record.

REQUEST BY PARENT FOR CHILD'S RECORD

A request by a parent for access to his or her child's record (under the age of 18 years) will be made in writing and submitted to the commanding officer of the Naval activity from which the child was seen for clinical counseling. Upon receipt of the request by the CO, the client will be provided with a copy of the clinical counseling record. If possible, review of the record should occur while a professional clinical staff member is present in case the client has questions and/or concerns about the record. Access to a child victim's records by a parent who has been substantiated for abuse of the child is restricted. Access does not extend to confidential materials other agencies have provided to the FSC. Consultation with the local JAG for further guidance is recommended.

REQUEST BY DoD PERSONNEL FROM OUTSIDE THE FSC AND ROUTINE USERS

A request for record access by DoD personnel from outside the FSC and routine users will normally be in writing and signed by the person seeking the records. The Privacy Act allows the FSC to disclose information from a client's record without the consent of the client (a) to certain DoD personnel from outside the FSC in certain carefully defined cases; and (b) for "routine uses" that are published in the *Federal Register* and included in the Privacy Act Statement given to FSC clients. This information is outlined in Attachment 1. In the case of a request by an organization such as a governmental agency, the signature should be that of a person holding a position of significant authority in the organization, or at least equivalent to that of the head of the local branch of the organization. **The decision to approve or disapprove the request will be made by the FSC Chief of Clinical Services and the FSC Director after consultation with the local JAG officer.**

REQUEST UNDER THE FREEDOM OF INFORMATION ACT (FOIA)

A Freedom of Information Act request for a FSC record will be handled in accordance with the Freedom of Information Act and SECNAVINST 5720.42E. Consult with your local JAG office for all FOIA requests.

OTHER REQUESTS

Any other request for record access must be submitted in writing stating fully the "need to know" or other statutory basis for access, and must be processed through the chain of command to Commander, Personal, Family, and Community Support Division (PERS-66) for disclosure determination. If a court subpoena is involved, consult with the local JAG officer.

PART THREE:
Administrative Case Record Management

This section covers the administrative management of a clinical case record material from the onset of service delivery to closing of the record. Detailed guidelines outline necessary procedures, forms, and staff responsibilities. These functions are a reflection of Accreditation Quality Standards. As an organizational model, administrative case record management functions have been grouped into five major areas:

(1) Initial Development and Control of Case Records

(2) Maintenance/Management of Case Records

(3) Reporting Forms

(4) Disposition of Cases

(5) Confidentiality of Case Records

3.1 INITIAL DEVELOPMENT AND CONTROL OF CASE RECORDS

3.1.1 PURPOSE OF OPENING A CASE RECORD

The purpose of a clinical case record is to establish a clearly defined, formal system of recording client services from initial contact through case closure. A case record is opened when clinical services are provided on the basis of client request, command referral, extended information and referral or the splitting of an already existing case (e.g., family counseling clients who begin individual counseling).

3.1.2 GUIDELINES FOR OPENING A CASE RECORD

3.1.2.1 CLINICAL REQUIREMENTS

- **Walk-Ins**
  If a client walks in to the FSC, is seen by a clinical provider, and services beyond simple information and referral are provided to the client, a case record is opened and the appropriate paperwork is completed. However, if the client needs only specific information and the contact is brief, then an Intake Form (Refer to Attachment 10) should be used to document the client contact. As general guidance, if the clinical provider does no more in person than they would have done with an intake phone call, it is considered an intake and a case record is not opened.

An individual case record is opened for each individual for whom service is provided, (i.e. for marital counseling cases, a record is opened for both the husband and for the wife).

- **Appointments**
  Clients who are seen by appointment are designated as "active" cases and a case record is opened and the appropriate paperwork is completed.

- **Phone-Ins**
  Although most phone-in requests for service can be adequately documented on an intake form, there are situations requiring that extended intake, intervention, and follow-up be conducted over the telephone (e.g., the client cannot come into the FSC). Documentation for such extended intake situations might include case activity notes to track the frequency, type, and level of intervention and follow-up provided, but it is not an official case without a signed and witnessed Privacy Act Statement. It is not legal for the clinical provider to sign the Privacy Act Statement for phone-in clients; however, arrangements can be made to mail the Privacy Act Statement to the client for signature and return. Then, with the client's agreement, an official case record may be opened.

3.1.2.2 ADMINISTRATIVE REQUIREMENTS

3.1.2.2.1 ASSIGNING A CASE RECORD NUMBER

All case records must be assigned a number for tracking purposes and case records should be numbered sequentially. FSCs also need to determine when to start the numbering of case records (either at the start of the fiscal year or the calendar year). FSCs should design a case numbering system which best meets its needs as long as

each case record is systematically numbered and filed for easy retrieval. The case records numbering system should **NOT** utilize the sponsor's social security number to identify the record. The case record numbering system should be detailed in the FSC's case record management SOP. The SOP should also address the need to assign a new case number to closed cases which are re-opened.

3.1.2.2.2 OBTAINING QUALITY OF LIFE MANAGEMENT INFORMATION SYSTEM (QOLMISNET) DATA

FSCs worldwide are required to document on QOLMISNET certain demographic and clinical counseling contact data about the clients they are serving. The client information form or Master Client Record form/face sheet for all case records must be standardized so that the appropriate information can be documented when a case record is opened (Refer to Attachment 12). Clinical providers can also refer to the QOLMISNET User's Guide within their FSC for more information.

3.1.2.2.3 MAINTAINING A MASTER CLIENT CASE LOG

A Master Client Case Log of all cases and the number assigned to them must be kept in order to track cases. The log should be documented either on computer or hard copy to provide a record of all cases seen at the FSC and to ensure no two cases are assigned the same number.

The Master Client Log also is maintained to assist with caseload monitoring (i.e. worker: caseload ratios); and to track length of time cases are maintained on an "open" status. The Master Client Log should be reviewed no less than **quarterly** to ensure the log data is purged along with caseload files that have been inactive for **two** years (Refer to Attachment 12 for sample).

3.1.3 MODEL CASE RECORD

3.1.3.1 CASE RECORD ORGANIZATION

It is recommended clinical case records be arranged in a manila-style file folder. All case material should be bound inside the record folder (with bifold clamp) to ensure records remain intact, orderly, and professional.

Each case record will include:

A. On the left side of the case folder from the bottom up:

(1) A signed and witnessed Privacy Act statement

(2) A signed and witnessed Client's Rights and Responsibilities form

(3) All correspondence, in chronological order, with the most recent correspondence on the top.

(4) Administrative Review form

(5) Completed Master Client Information form/Intake form.

(6) Disclosure of Information form, if required.

(7) Record of Contacts

B. On the right side of the case folder from the bottom up:

(1) All clinical case information transferred from other sources

(2) Completed psychosocial assessment, including client psychosocial history

(3) Case notes, most recent on the top

(4) Clinical Review form

(5) Closing Summary, when appropriate

3.1.3.2 CASE RECORD ENCLOSURES

Case record enclosures are listed below. Samples of these enclosures are also included in the Appendix.

REQUIRED:

- Record of Disclosure Form (5211/9) - (when appropriate) - **Attachment 2**
- Master Client Information form/Face Sheet - **Attachment 12**
- Privacy Act Statement
  - Signed and witnessed FSC Privacy Act Statement - **Attachment 1**
  - Personal Reliability Program (PRP) Statement - (when appropriate) - **Attachment 3**
- Signed and witnessed Release of Information Statement(s) (when appropriate)
  - Authorization to release information to a third party - **Attachment 6**
  - Authorization for child to receive counseling at FSC - **Attachment 14**
  - Authorization to counsel child without parent(s) present - **Attachment 15**
  - Authorization to audio/video tape or observe counseling session - **Attachment 16**
  - Authorization to disclose records to a student intern - **Attachment 17**
- FAP Incident Report (if applicable)
- Intake/History Assessment Form - **Attachment 26**
- Treatment Plan - **Attachment 19**
- Case Activity Notes
- Documentation of Referrals & Follow-up (in case activity notes or on separate sheet)
- Case Closure Form - **Attachment 21**
- Client PsychoSocial History
  - Adult - **Attachment 22**
  - Youth - **Attachment 23**
- A written explanation of services
- Client's Rights and Responsibilities - **Attachment 24**
- Record of Contacts Form - **Attachment 18**

RECOMMENDED:

- Intake/Referral Form - **Attachment 11**
- Inventories/Tests (if conducted, they are required)

3.1.4 STANDARDS FOR CASE ACTIVITY NOTES

There should be a case activity note entry for every client or client-related contact (e.g. sessions, telephone calls, consultations, FAP reports, feedback to referrals, etc.) Notes must be completed within 48 hours of routine client visits. Crisis intervention services should be documented immediately. Notes should be factual and objective. The clinical provider should always keep in mind the possibility that a case record could be read by other individuals (e.g., court review) and therefore determine what needs to be documented. Each entry must be signed and dated and legible via a computer or a typewriter. Refer to Part 4 for a description of the SOAP format.

3.2 MAINTENANCE AND MANAGEMENT OF CASE RECORDS

3.2.1 CASE RECORD STORAGE

FSCs should maintain a central clinical counseling case record system. The FSC Director and Chief of Clinical Services should have access to clinical counseling case records in the event that a critical situation with a client arises and the clinical provider is not available.

This central case record system should be housed in a double locked system which includes a lockable cabinet which is secure at all times and is inside an office or storage space which can be locked at the end of the day. A master case log should be maintained where all cases are logged in to facilitate the retrieval of records. This log should be secured as part of the case record storage system. The FSC case record storage system should be documented in an SOP which explains the type of numbering system being utilized, where and how case records are filed, the system of checks and balances which ensure case record documentation is occurring on a timely basis, etc.

3.2.2 SAFEGUARDING CASE RECORD MATERIALS

At the close of daily business or when FSC clinical staff are out of the building, all clinical case record materials will be cleared from desktops and routing boxes and will be kept in locked file drawers. Case record materials include:

- Client Information and Face Sheets
- Documents or notes which contain identifiable client information
- Inquiry and referral sheets

- Recording summaries
- Correspondence

Clinical counseling records are to be maintained in a manner consistent with the Privacy Act (Refer to Section 2.2). Only authorized clinical staff members will handle case record materials. Authorized FSC staff members include:

- Clinical Supervisor
- Clinical Providers
- Designated Administrative/Support Personnel
- FSC Director
- Personnel entering case record material on data processing equipment for electronic storage

Case records may be removed from the FSC premises only with the consent of the FSC Director or Clinical Supervisor. Case record removal will be approved only for official purposes, such as a court subpoena or request from the FAP Case Review Committee. If the FSC Director or Clinical Supervisor checks out a record, the other approval source must grant check-out approval.

3.3 REPORTING FORMS

Required reporting forms used within the FSC include the following:

- Statistical Contact Form: QOLMISNET Data (Refer to Attachment 12)
- Critical Incident Report Forms
  - (a) Family Advocacy Incident Report Form (Refer to Attachment 36)
  - (b) Safety Assessment and Safety Response (Refer to Attachments 37-38)
  - (c) Reporting Child Abuse to a Civilian Agency

  When the Department of Social Services Child Protective Services Unit is contacted regarding suspected child abuse/neglect, it must be fully documented in the client's case record. There is no specific form for this purpose, but the following information should be included:

  – The date of contact
  – The reason for reporting

– Point of contact at the agency
– Case disposition
– A plan for follow-up either by the agency or FSC

(c) Referral for Psychiatric Evaluation

When an active duty member is referred for a psychiatric evaluation by an FSC clinical provider, a referral form noting the clinical provider's initial assessment and reason for requesting a psychiatric evaluation should accompany the client and be given to the General Medical Officer. This form documents the referral for psychiatric evaluation and encourages the medical command to follow-up with the FSC clinical provider (Refer to Attachment 25 for sample form).

3.4 DISPOSITION OF CASES

The disposition of a case should be noted on the Intake Log (Refer to Attachment 10). The disposition of a case falls into three categories:

3.4.1 ASSIGNMENT TO FSC CLINICAL PROVIDER

The client is assigned to a FSC clinical provider. Each FSC should have procedural guidelines for assigning cases within the FSC. These guidelines should be based on the criteria that clients are required to meet in order to receive clinical counseling services from FSC which is dependent on a variety of factors including:

- Availability of referral resources in the civilian community.
- Size of the clinical counseling staff.
- Level of client demand for services.

The Clinical Supervisor is responsible for ensuring that cases are distributed to the clinical counseling staff in the most equitable manner possible. Local conditions and staffing patterns play a vital role in determining how cases will be assigned. Other factors which may be considered include:

- Size of the clinical provider's ongoing caseload;
- Level of the clinical provider's clinical experience;
- Profile of the clinical provider's already existing caseload (i.e., number of complex

cases, types of cases such as individual, marital, family);

- Designation of the provider's clinical privileging status;
- Availability of appointments.

3.4.2 REFERRAL

The client who seeks assistance at the FSC should always be referred to the most appropriate resource. One of the major goals of the FSC is to provide assistance to clients without duplicating already existing resources. Client needs are evaluated through the initial intake screening process, assessment of the client's situation and needs, and consultation with the client about the resources available to him or her. The client then may be referred to a resource or program within the FSC, such as financial counseling, a deployment support group, or a parenting class. The referral could involve a resource outside of the FSC but within the military community, such as Navy Marine Corps Relief Society, a Chaplain, or Alcohol Rehabilitation Department (ARD). The client may be referred to a resource or TRICARE -approved provider in the local civilian community. Proper guidelines must be adhered to when making a referral. The "rule of three" applies, which means that a minimum of three resources (if available) should be given to the client who will then make the decision as to which provider to use. All referrals should be documented in the case record. The referrals may be noted within the text of the case activity notes or a separate sheet listing referrals may be included in the case record. Refer to Part 4 for more detailed referral guidelines. It should be noted some locations have restrictions through TRICARE which prohibits direct referrals to clinicians. Local TRICARE distinctions should be documented in an SOP.

Sound clinical practice dictates some type of follow-up be conducted when referring a client for services. The following criteria should be considered in order to close the loop and ensure the client's integrity is protected.

- Ensure client's release of information form is signed and witnessed.
- If faxing information about a client, make sure that the recipient is physically present to receive any sensitive information.
- Call referral source 1 or 2 weeks following referral to make sure client has made a successful link.
- When referring FAP cases, make a note of the date in the case record.
- Follow-up with the FAR regarding the disposition of client cases.

3.4.2.1 ELEMENTS OF A REFERRAL SYSTEM

ELEMENT	TASKS
Responsible Staff	❑ Identify individual responsible for clinical counseling referral system.
Resource Development	❑ Organize a resource file by "type" ❑ Determine Availability ❑ Check Credibility ❑ Willingness to follow-up ❑ Military experience ❑ Credentials ❑ Specialty ❑ Intake process ❑ Resource visits to FSC ❑ Site visit to resource ❑ Fees/TRICARE eligibility
Maintenance of Resources	❑ Update Resource List ❑ Maintain Relationships ❑ Community Networking - Participate in joint programs, luncheons, etc. ❑ Survey/Form of referrals - Impressions of FSC - Willingness to follow-up
Resource Utilization	❑ Rule of Three, when appropriate ❑ How to Link ❑ Confidentiality ❑ Guidelines for Clients - Resource Information

3.4.2.2 ROUTING OF REFERRAL INSTRUMENT

To Client	FSC Documentation	To Provider	From Provider To FSC
Form, letter, or card given to client with referral information	In Case Record: - Statement of referral made - Was referral completed - Provider and/or client feedback - Dates Referral made entry at provider site	As required by local FSC procedures	Verbal or written format: - Referral completed - Status - Appropriate
Rule of Three - Name of three providers when appropriate	On Intake Referral Form or In Case Record		Written Format Only - Documentation for FAP

3.4.3 CASE CLOSURE

A case is closed when the client does not require or does not want services any longer. The Chief of Clinical Services is responsible for reviewing a random sample of cases closed each quarter by privileged clinical practitioners. For non-privileged clinical providers, the Clinical Supervisor must approve and review all case closures. Refer to attachments for a sample case closure form. They include the following types:

- Closing Summary Form (Refer to Attachment 20)
- Case Closure Forms (Refer to Attachment 21)

The case closure should be noted in the Master Case Log.

3.5 STORING AND DESTROYING CLOSED CASE RECORDS

Closed clinical case records should be placed in locked storage for a period of 2 years following last contact and closure, then destroyed. Electronic records are maintained for a period of five years and then destroyed. Designated administrative personnel should destroy paper records in a burn bag or shredder. Magnetic records can be erased or degaussed.

3.6 CONFIDENTIALITY OF CLINICAL CASE RECORDS

Confidentiality guidelines are outlined in Part 2; specific information on confidentiality in regard to access to client case records is addressed in Section 2.8. Case records should be reviewed to ensure the appropriate confidentiality forms are signed and witnessed and part of the case record enclosures.

3.7 SUMMARY

The following matrix provides an overview of administrative case record management roles and responsibilities within the FSC.

ADMINISTRATIVE CASE RECORD MANAGEMENT ROLES AND RESPONSIBILITIES

Case Record Management Activities	Director	Chief of Clinical Services	Clinical Provider	Admin Staff
1. Open Record		A	R	S
Assign Case No.			I/R	R/S
Log In			I/R	R/S
2. Storage/Security				
Policy	R	R	I	I
Implement	R	R	R	
3. Update/Maintenance		A	R	
4. Admin. Record Review	R			
5. Clinical Case Record Review		A/R	R/S	
6. Collect Statistics			R	S
7. Analyze Statistics		R	S	
8. Report Statistics		R	S	
9. Transfer		A	R	S
10. Closure		A	R	S
11. Disposition	A	A	R	S
12. Requests for Release of Information Routine				
(FOIA)	I/A	A/R	R/S	S
Nonroutine	I/A	A/R	R/S	
13. Need to know DoD/Command	I	I	R	
14. Confidentiality	R	R	R	R

Functions:

A = Approve S = Support R = Responsible I = Inform

PART FOUR:
Clinical Case Management

4.1 DEFINITION

Clinical case management is defined as a process for efficient management of client case information which maintains organizational quality control and clinical accountability. The provision of clinical case management ensures clients receive the highest caliber and quality of clinical services available.

As defined for use within the FSCs clinical case management based on:

(1) Effective assessment,

(2) Determination and assurances of client safety,

(3) Utilization of client assets,

(4) Minimization of client dependency, and

(5) Client acceptance of responsibility for problem resolution.

Case management includes the following essential components:

(1) Effective coordination of available community resources,

(2) Follow-up with referral sources,

(3) Tracking of case progress,

(4) Completion and maintenance of forms, reports, and records, and

(5) Documentation of case closure or transfer.

The Chief of Clinical Services is responsible for monitoring clinical case record management procedures to ensure that client records are established, reflect accurate information regarding the client's situation, contain the required documentation, and are closed in a timely manner.

4.2 INTAKE SCREENING

4.2.1 DEFINITION AND PURPOSE

INITIAL SCREENING: The first contact with FSC staff determines eligibility for FSC services and the appropriateness for FSC services. Initial screening may be performed by a nonclinical staff person who is fully cognizant of all FSC programs and services and will ensure that the client is referred for a comprehensive intake assessment if appropriate.

Intake Screening is the first step in the clinical counseling process. It is an integral part of crisis intervention and short-term clinical counseling. Only with proper screening can the appropriate decisions be made about problem resolution. The purpose of intake screening is to:

- Develop a clear picture of the walk-in or call-in client's situation and needs.
- Assure that clients who are best served by the FSC are connected to the most appropriate program or service quickly.
- Assure that clients who can be well-served by other agencies are spared being "processed" at FSC before reaching the appropriate agency.
- Provide informational support to the Information and Referral staff.
- Handle all client contacts in a manner which will encourage clients to use the services offered by the FSC and to refer other individuals to FSC for assistance.

INTAKE ASSESSMENT: A formal clinical assessment which includes an intervention and initial service plan and must be conducted by a credentialed clinical provider. A thorough assessment requires the clinical provider to obtain from the client a personal history and to conduct a mental status exam (to the extent indicated by the initial assessment) (Refer to Attachments 11, 22 & 26).

4.2.2 GUIDELINES FOR HANDLING TELEPHONE INTAKES

The most critical component in intake screening is acquiring sufficient information about the client's situation to permit the clinical provider to make an appropriate assessment of the caller's request.

Questions which help the intake worker define the caller's service needs include, but are not limited to, the following:

- Is the caller in a state of crisis?
- Is the call an emergency?
- If either of the above, who does the caller believe to be at risk?
- What is the caller's definition of the problem?
- What is the caller's interpretation or explanation of the cause of the problem?
- How long has the problem or condition existed?
- What does the caller believe will help relieve or eliminate the problem?
- How realistic are these ideas?
- Are there any pressing situational conditions which affect the problem or inhibit problem solving? (e.g., deployment, lack of transportation, lack of funds, poor health, pregnancy, etc.)
- Which family members or other persons are involved in the problem and what are their attitudes toward seeking help?
- Where does the caller live and work? (hours of work and their flexibility, etc.)
- How motivated is the caller to follow through with a telephone referral?
- Would the caller be more likely to follow through if first given an opportunity for in-person support and clarification at the FSC?

4.2.3 GUIDELINES FOR DEVELOPING INTAKE SCREENING FORMS

An intake log is a record of requests (by phone or walk-in) for services through the clinical counseling unit (Refer to Attachment 10). Calls from referral sources will also be recorded in the intake log by the name of the caller. A log folder should be kept for each month's intake log. This log is completed for all requests and is used for documentation of contact and as a point of reference should the caller call back or come in for an appointment.

An intake referral form should be completed by the intake worker or the clinical provider responding to a request for services (Refer to Attachment 11). It should include information required by QOLMISNET. Important information to include is:

- Client identification information: name, telephone, address, duty station, sponsor, rate, and rank
- Referral source: role, name of person, telephone number
- Old or new case: has the client been seen previously at any FSC
- Problem identification: client's and/or referral's statement of problem
- Service request: client's and/or referral's request for action taken
- Disposition: action taken

The form should be filled out as completely as possible with particular attention taken to (1) phone numbers, so a client can be called back if necessary; and (2) the appropriateness of the disposition based on the synopsis of the problem.

4.2.3.1 PHONE INS

An intake referral form will be completed by the intake worker or the clinical provider (Refer to Attachment 11). All intake forms that do not result in a scheduled interview with a FSC clinical provider will be kept in the intake folder for two years. In situations that warrant documentation because of extended intake services, interventions, and follow-up by telephone, a Privacy Act Statement may be mailed to the client for signature and return so an official case record can be established. It is not legal for the clinical provider to sign the Privacy Act Statement on the client's behalf.

4.2.3.2 WALK INS

Record keeping for walk-in clients is kept in one of two ways: If significant service is provided to the client, then a **case record** is opened and the appropriate paperwork is completed. If the client needs only specific information and the contact is brief, then an **intake form** should be used. In both instances, a Privacy Act Statement must be signed and witnessed and attached to either the case record or the intake form. As general guidance if you do no more in person than you would have done with an intake phone call, it is considered intake and it is not necessary to open a case record.

4.3 ASSESSMENT

4.3.1 DEFINITION AND PURPOSES

ASSESSMENT: A determination of a presenting problem using an in-depth clinical interview. The purpose of an assessment is to develop an effective and appropriate intervention plan that will fit the client and the presenting problem. An assessment must be conducted by a credentialed clinical provider.

4.3.2 GUIDELINES FOR DEVELOPING AN ASSESSMENT FORM

Although the information which must be included in a comprehensive assessment is complex, the assessment form itself should be simple with a broad scope. General areas to be covered include:

- **Statement of Presenting Problem:** The client's interpretation of his or her problem, which might also include information about the precipitating event that led the client to seek assistance from the FSC.
- **Referral Source:** Indicate source of referral and note if command referred.
- **Relevant History:** Information about the client's psychosocial history or family of origin history; information from the Master Client form and from the interview.
- **Clinical Impressions:** The FSC clinical provider's assessment of the client's problem based on the client's statement of the presenting problem, the client's relevant history, and the mental status exam. A *DSM-IV* diagnosis is included as part of the clinical impression.
- **Treatment Plan:** Intervention and goal setting which is behavioral based and measurable.

4.4 DIAGNOSING WITH *DSM-IV*

In accordance with Accreditation Quality Standards, clinical providers in the FSC must be competent in the use of *the Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*, American Psychiatric Association, 1994). Each client should be evaluated and diagnosed using the criteria set forth in the *DSM-IV*. Refer to Section 4.4.1 for additional information on *DSM-IV* Axes and V Codes often seen in the FSC setting. Diagnoses should be documented in the case record. Clinical providers must receive in-depth training in the application of the *DSM-IV* in completing a differential diagnoses. Training plans for clinical providers should be clearly stated in the local Clinical Counseling SOP.

In accordance with SECNAVINST 1754.1A, Navy Family Service Center Program, clients who present with an Axis II diagnosis are beyond the scope of FSC clinical counseling service delivery. These clients may be referred to medical, (if active duty), or to community clinical providers, (if family members). It is critical for clinical providers to make an accurate diagnosis in order to refer clients to the most appropriate resource available. All treatment plans, case record notes, and requests for extensions of services must reflect the *DSM-IV* diagnosis.

4.4.1 DSM-IV DIAGNOSIS OVERVIEW

Axis I – Clinical Disorders (but not personality disorders) and other conditions that may be a focus of clinical attention (most V codes).

Axis II – Personality Disorders (long-standing/characterological patterns, in adults) and Mental Retardation.

Axis III – General Medical Conditions

Axis IV – Psychosocial and Environmental Problems

Axis V – Global Assessment of Functioning (GAF) Scale

AXIS I

- Disorders usually first diagnosed in infancy, childhood, or adolescence.
- Delirium, Dementia, and Amnesic and other cognitive disorders.
- Mental Disorders due to a general medical condition.
- Substance-Related Disorders
- Schizophrenia and other psychotic disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Sexual and Gender Identity Disorders
- Eating Disorders
- Sleep Disorders
- Impulse-Control Disorders not elsewhere classified
- Adjustment Disorders
- Other Conditions that may be a focus of clinical attention

- V Codes (most frequent diagnostic code used in FSCs):
  - V15.81 Noncompliance with Treatment
  - V61.1 Partner Relational Problem
  - V61.1 Physical Abuse of Adult
  - V61.1 Sexual Abuse of Adult
  - V61.20 Parent-Child Relational Problem
  - V61.21 Neglect of Child
  - V61.21 Physical Abuse of Child
  - V61.21 Sexual Abuse of Child
  - V61.8 Sibling Relational Problems
  - V61.9 Relational Problem Related to a Mental Disorder or General Medical Condition
  - V62.2 Occupational Problem
  - V62.3 Academic Problem
  - V62.4 Acculturation Problem
  - V62.81 Relational Problem NOS
  - V62.82 Bereavement
  - V62.89 Borderline Intellectual Functioning
  - V62.89 Phase of Life Problem
  - V62.89 Religious or Spiritual Problem
  - V65.2 Malingering
  - V71.01 Adult Antisocial Behavior
  - V71.02 Child or Adolescent Antisocial Behavior
  - V71.09 No Diagnosis on Axis II
  - V71.09 No Diagnosis or Condition on Axis I

AXIS II

- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder
- Antisocial Personality Disorder
- Borderline Personality Disorder
- Histrionic Personality Disorder
- Narcissistic Personality Disorder
- Aviodant Personality Disorder
- Dependent Personality Disorder
- Obsessive-Compulsive Personality Disorder

- Personality Disorder Not Otherwise Specified
- Mental Retardation

AXIS III

- Infectious and Parasitic Diseases
- Neoplasms
- Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders
- Diseases of the Blood and Blood-Forming Organs
- Diseases of the Nervous System and Sense Organs
- Diseases of the Circulatory System
- Diseases of the Respitory System
- Diseases of the Digestive System
- Diseases of the Genitourinary System
- Complications of Pregnancy, Childbirth, and the Puerperium
- Diseases of the Skin and Subcutaneous Tissue
- Diseases of the Musculoskeletal System and Connective Tissue
- Congenital Anomalies
- Certain Conditions Originating in the Perinatal Period
- Injury and Poisoning

AXIS IV

1. Problems with primary support groups—death of family member; health problems in family; disruption of family by separation, divorce, or estrangement; removal from the home; remarriage of parent; sexual or physical abuse; parental overprotection; neglect of child; inadequate discipline; discord with siblings; birth of a sibling.

2. Problems related to social environments—death or loss of friend; inadequate social support; living alone; difficulty with acculturation; discrimination; adjustment to life-cycle transition (retirement, relocation, etc).

3. Educational problems—illiteracy; academic problems; discord with teachers or classmates; inadequate school environment.

4. Occupational problems—unemployment; threat of job loss; stressful work schedule; difficult work conditions; job dissatisfaction; job change; discord with boss or coworkers.

5. Housing problems—homelessness; inadequate housing; unsafe neighborhood; discord with neighbors or landlord.

6. Economic problems—extreme poverty; inadequate finances; insufficient welfare support.
7. Problems with access to health care services—inadequate health care services; transportation to health care facilities unavailable; inadequate health insurance.
8. Problems related to interaction with the legal system/crime—arrest; incarceration; litigation; victim of crime.
9. Other psychosocial and environmental problems—exposure to disease, war, other hostilities; discord with nonfamily caregivers such as clinical providers, social worker, or physician; unavailability of social service agencies.

AXIS V:

Ratings are made of current level of psychological/social/physical functioning and for highest level in past year.

Example: GAF: Current = 54; Highest in past year = 92.

91-100	Superior functioning, no symptoms
81-90	No or minimal symptoms, generally good functioning in all areas, no more than everyday problems or concerns.
71-80	Transient, slight symptoms that are reasonable responses to stressful situations. No more than slight impairment in social, occupational, or school functioning (SOSF)
61-70	Mild symptoms or some difficulty in SOSF
51-60	Moderate symptoms or moderate difficulties in SOSF
41-50	Serious symptoms or any serious impairment in SOSF
31-40	Serious difficulties in thought or communication or major impairment in several areas of functioning
21-30	Behavior influenced by psychotic symptoms or serious impairment in communication or judgement or inability to function in almost all areas
11-20	Dangerous symptoms or gross impairment in communication
1-10	Persistent danger to self or others or persistent inability to maintain hygiene
0	Inadequate information

4.4.1.1 *DSM-IV* TRAINING & REFERENCE RESOURCES

Resources that can provide information for training in the use of the *DSM-IV* are listed below:

Alger, I., Ed. (1995). *DSM-IV: New diagnostic issues* [videotape]. Washington, DC: American Psychiatric Association.

American Psychiatric Association. *DSM IV* Source Book.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Frances, A., First, M. B., & Pincus, H. A. (1995). *DSM-IV guidebook.* Washington, DC: American Psychiatric Association.

Frances, A. & Ross, R. (1996). *DSM-IV case studies: A clinical guide to differential diagnosis*. Washington, DC: American Psychiatric Association.

First, M. B., & Frances, A. (1995). *DSM-IV handbook for differential diagnosis*. Washington, DC: American Psychiatric Association.

Morrison, J. (1995). *DSM-IV made easy: The clinician's guide to diagnosis.* NY: Guilford Press.

Morrison, M. Robert, and Stamps, Robert F. (1998). *DSM IV* Internet Companion. WW Norton, Co.

Othmer, E., & Othmer, S. C. (1998) Clinical Interview Using *DSM IV* - Vol. 1 Fundamentals. American Psychiatric Press.

Othmer, E., & Othmer, S. C. (1995). The Clinical Interview Using *DSM-IV.* (Vols. 1 and 2). Washington, DC: American Psychiatric Association.

Turner, F. J., Ed. (1995). *Differential diagnosis and treatment in social work* (4th ed.). NY: Free Press.

4.5 TREATMENT PLAN

4.5.1 DEFINITION AND PURPOSE

A treatment plan involves the documentation of structured intervention(s) designed to alleviate a client's presenting problem. The purpose of a treatment plan is to define client/clinical provider's goals, to specify the intervention(s) which will be used and how they will be applied, and the method(s) which will be used to measure a client's progress.

4.5.2 GUIDELINES FOR DEVELOPING A TREATMENT PLAN

A treatment plan must be a direct reflection of the *DSM-IV* diagnosis. General areas to be covered in a treatment plan include:

- Statement of the problem
- *DSM-IV* diagnosis
- Goals (must be measurable/behavioral)
- Intervention plan
  - Identified client(s)
  - Length of clinical counseling
  - Frequency of sessions
  - Type of clinical counseling (individual, marital, group, etc.)
  - Referrals
  - Client contract (if appropriate)

The written treatment plan should be concise and straightforward. Consistency in the content of the treatment plan is vital to ensure clients receive the best service possible and documentation in a client's record is thorough and complete (Refer to Attachment 19 for sample).

4.5.3 ELEMENTS OF AN EFFECTIVE TREATMENT PLAN

An effective treatment plan integrates and operationalizes the treatment goals and objectives identified by the client receiving services at the FSC. A primary purpose of the treatment plan is to succinctly document the interventions and progress toward stated goals.

The elements of the treatment plan should include:

- Overall Goal: The clinical provider states in concrete, measurable, and behavioral terms the intervention(s) which should result in changes to the initial presenting problem(s);
- Objectives: The clinical provider should list in behavioral terms what step(s) the client will be required to take in order to obtain the overall goal.
- Interventions: List the techniques the clinical provider will utilize to assist the client in obtaining the desired outcome.

- Counseling Modality: Identify the clinical counseling modality that will be utilized to achieve the desired outcome (e.g., cognitive, behavioral, solution-focused, etc.)
- Identify Clients: During the initial assessment, identify clients who will be participating in treatment.
- Length of Clinical Counseling: State the projected length of treatment to achieve stated goals.
- Frequency of Sessions: Identify the frequency of the clinical counseling sessions.
- Referrals: Document all referrals and their relationship to the stated treatment goals.

Clinical providers most often have difficulty when they have not established realistic, well-formulated outcomes for treatment plans –

1. What do you want? — Must be stated in positive terms and must be under the control of the client – not, "I want him to stop …."
2. How would you know if you had accomplished the goal? — Establishes the client's self-measure of when the outcome has been achieved.
3. How would I know if you had accomplished the goal? – Offers the objective criteria by which the clinician will know when the outcome has been achieved.
4. Is there any time you would not want this outcome? – Is a reality check for when the outcome is wanted under specific circumstances. At times, the outcome may actually be undesirable.
5. What prevents you from having your outcome right now? – Establishes the treatment issues.

4.6 CASE ACTIVITY NOTES

Case activity notes are written to document what occurred during each clinical counseling session. These notes should encompass problem identification, assessment, and implementation of treatment goals, which must reflect the client's *DSM-IV* diagnosis. Documentation must be completed and placed in the client file **WITHIN 48 HOURS** of client visits. Crisis intervention services should be documented **IMMEDIATELY**. Each case activity note must be dated and signed by the FSC clinical provider. The FSC clinical provider's name should be stamped under the signature.

Signature or co-signature by the clinical supervisor is required on all case activity notes generated by non-privileged clinical providers.

While current Navy policy does not mandate a specific format for case activity note documentation, the FSC should develop a specific written protocol for a structured note format which documents client contact in a clear and concise manner and which focuses on progress toward specific goals. The SOAP format is the structured and traditional format recommended for use in FSCs to maintain consistency in case documentation across clinical providers.

NOTE: Case documentation in FAP records does NOT require the SOAP format.

4.6.1 SOAP FORMAT

The SOAP note provides the FSC clinical provider with a structured framework for recording the content of clinical counseling sessions. It requires the FSC clinical provider to organize his or her thoughts in a concise manner by delineating the four key elements of any client contact. SOAP notes have the unique advantage of being read quickly and easily by a new FSC clinical provider taking over a case or during a quality assurance review. Refer to Section 4.6.1.1 for a sample SOAP format case note.

S = SUBJECTIVE DATA

The clinical provider writes "S" and then describes or quotes the client's view of the problem. "S" is what the client tells the clinical provider. Subjective data "S" includes:

1. The client's perception of his/her problem
2. What the client thinks or believes is wrong
3. The client's description of his/her symptoms
4. Direct quotes from the client about his/her problem

O = OBJECTIVE DATA

The clinical provider writes "O" and then records factual data and observations here. "O" is information that can be verified by others. The client's personal appearance and/or behavior may be described but not assessed. Relevant details concerning the client's finances, living arrangements, and so forth may be included. Objective data "O" includes:

1. What the clinical provider can observe about the client(s): For example:

a. Appearance, posture, body language
b. Behavior, overt expressions of emotion
c. Conversation, affect, stated mood
d. Memory

2. Results of any psychiatric evaluation
3. Verified medical data, obtained from medical records bearing on the client's mental health questions being considered.

A = ASSESSMENT

The clinical provider writes "A" and then provides analysis of the meaning of the client's perceptions and the factual observations. "A" is the conclusions/ conceptualizations of the clinical provider after analysis of the subjective and objective data. Assessment "A" includes:

1. Synthesis of Subjective and Objective findings
2. Best behavioral description, including any S/H ideations, safety issues, etc.
3. Formal diagnosis according to *DSM IV*

P = PLAN

The clinical provider writes "P" and then states what he or she plans to do for the resolution of the identified problem(s). The client's responsibilities should be stated. Discussion of the session (homework discussion, modeling of a behavior, etc.) can be included here as well as the scheduling of the next session. Plan "P" also includes:

1. Session discussion/explanations, modeling, etc.
2. Goals or treatment objectives and how they are (or are not) being met
3. How will the clinical provider share impressions and give instructions to client
4. Specific recommendations - referrals to other clinical staff (military and/or civilian), consults, referrals to other agencies/services (Navy Relief, PFM, Red Cross, EFM, etc.)

4.6.1.1 SAMPLE SOAP CASE NOTES

29 JAN 97: OV, Alice and Ted with Sam and Carol:

S: Alice stated she had called to schedule the session because Ted had told her to call. Alice reported "Ted yelled at me because I did not ask more questions of the doctors and the physical therapist about Carol's treatment. I am asking more questions, but I don't like it when Ted yells at me like I have done something

wrong." Alice said "I like it when Ted helps with the children and gives me a rest when he come home."

0: Alice is a 28 y.o. WF, casually dressed in a tee shirt and jeans with a new short haircut. She was appropriately groomed, alert and oriented X 3, and denied any violent ideation. Alice's affect was appropriate and she fed Carol and held her in a relaxed and competent manner during the session. Her thought processes were characterized by fluent, relevant speech and her thought content was devoid of psychotic features.

A: Alice appeared more comfortable during the session; she initiated some of the comments instead of allowing Ted to control the session. She seems to defer to Ted and to be hesitant about telling him how she feels/thinks. Alice's quiet demeanor lends to her appearance of non-assertiveness.

Relational Problem Related to a Mental Disorder or General Medical Condition (Carol has spinal bifida) and Partner Relational Problem

Prognosis: Fair

P: Discussed using time-outs when needed to assist in conflict resolution and the need for couple's respite when possible. Explained the listening exercise; requested the couple practice the exercise every night. Conjoint therapy for six more sessions – 5 more sessions on communication and on conflict resolution, and 1 on stress management. Scheduled the next session for 12 FEB, 1430.

29 JAN 97: OV, Ted and Alice with Sam and Carol:

S: Ted said "I do yell at Alice sometimes for not asking more questions of the physical therapist and then I apologize I am stressed, angry, and frustrated with Carol's needs. I don't understand why the physical therapist has told Alice to exercise Carol's upper body when it is her legs which are paralyzed." Ted stated he also gets frustrated when a neighbor's teenager comes over and then stays; Ted stated "She (the teenager) does help with the children but when I come home I want to spend time with my family without her around." When asked, Ted said he appreciated Alice for being a "good mother."

0: Ted is a 30 y.o. WM, neatly dressed in his USN denims with a "very short" military style haircut. Ted was alert and oriented X 3, denied any violent ideation and his

affect was depressed. His thought process was characterized by fluent, relevant speech and his thought content was non-pathological. Ted tended to control the discussion during the session. Ted sat with Sam on the couch; his interactions with Sam were warm and caring, and he smiled at Sam during some of Sam's games (Sam sang to the teddy bear and to himself).

A: Ted seems to want to work on his issues and to realize he needs to direct his stress, etc. elsewhere and not at Alice. Ted was able to identify "a tense neck" as a cue for using time-outs and/or relaxation techniques. Much of Ted's frustration seems to come from his not setting boundaries (i.e. the teenager).

Relational Problem Related to a Mental Disorder or General Medical Condition (Carol has spinal bifida) and Partner Relational Problem

Prognosis: Fair

P: Discussed using time-outs when needed to assist in conflict resolution, setting boundaries, and utilizing relaxation techniques. Suggested respite time as a couple. Contracted with Ted for no yelling at Alice. Explained the listening exercise and requested the couple practice it every night. Conjoint therapy for six more sessions – 5 more sessions on communication and on conflict resolution, and 1 on stress management. Scheduled the next session for 12 FEB, 1430.

SOME ADDITIONAL IDEAS:

The recording of each session should include:

1. Identifying data;
2. Results of a mental status exam (if change noted from previous contact);
3. Reference regarding dress, grooming, affect/mood, thought process and thought content (to support any conclusions from the clinician about risks, diagnosis, etc.)
4. Address the issue of violent ideation;
5. Diagnosis should be a diagnosis, not a narrative. Prognosis should be included, particularly on litigious cases in order to document the realistic expectations regarding the efficacy of treatment)
6. Plan should be very specific and include the date and time of the next session. In subsequent sessions, the plan can be "no change" or can be totally changed to meet a need.

4.7 DEVELOPING A REFERRAL SYSTEM

4.7.1 DEFINITION

REFERRAL SYSTEM: An organized method of linking clients with the most appropriate resource. Within the FSC clinical counseling unit, it is the utilization of military and civilian service providers to augment FSC clinical counseling services. Each FSC should have developed formal criteria to determine which category of client has top priority in receiving clinical counseling services (e.g., suicidal ideation seen immediately, marital problems put on waiting list, child with drug problem referred to private provider). It is essential a well-developed referral system be in place to ensure clients who are referred to private providers receive quality services in a timely manner.

NMPC A54 Ser156/A704, 11 May 1989, Guidance Memorandum - Family Service Center. Staff Training Confidentiality & Referral Procedures: Amplifies existing guidance with regard to client referral procedures.

4.7.2 REFERRAL PROCEDURES

4.7.2.1 REFERRAL INSTRUMENT

A referral instrument is the means by which the client receives the necessary information from the FSC and accesses the resource. It is recommended the FSC clinical counseling service unit develop a form where information can be filled in and given to the client to take with him or her. Each FSC can develop a written tool which meets their local needs. The following items should be included on a referral form:

- Date of referral
- Client's name
- Name, position, agency name, address and phone number of provider to whom client is being referred (remember the "rule of three" when appropriate)
- Name, position, agency name, address and phone number of person the referral is coming from
- Reason for referral
- Pertinent comments or additional information (as needed)

4.7.2.2 RULE OF THREE

There are specific client referral guidelines that FSCs are required to follow. Specific guidance for referring individual clients to community resources includes application of the "rule of three." The rule of three means that a minimum of **three** resources must be given to the client who will then make the decision on which provider to use. A rotating list of providers is the ideal approach to use whenever it is feasible. In overseas and remote locations it is understood that it can be difficult to always provide a choice of three outside providers. In these situations, every effort must be made to provide equitable distribution to the limited number of outside providers.

Obtaining the best professional assistance for a client should always be of the highest priority while avoiding even the appearance of conflict of interest. For example, if there is only one local provider who has specialized training and expertise in treating sexual assault cases, it may be appropriate to refer all such cases to the one provider. However, any referral not complying with the "rule of three" must be specifically approved by the Clinical Supervisor and/or the FSC Director in each case presented or be in accordance with the locally approved SOP for clinical services. If the referred is to TRICARE, not a provider, then the "rule of three" does not apply.

4.7.2.3 DOCUMENTATION

All referrals must be documented. If a client is directly referred to an outside provider as a result of an intake screening phone call, the referral would be noted on the intake referral sheet. When a case is formally opened, all referrals made must be documented in the client's case record. The referral should be noted in the text of the case activity notes. Whether the referral is made over the phone or in writing, it must be documented in the case record (Refer to Attachment 25 for sample).

4.7.2.4 CONFIDENTIALITY

Guidelines on confidentiality issues within the FSC are detailed in Part 2, Confidentiality. If any information is to be exchanged between the FSC clinical provider and a private practitioner regarding a client, the client must be willing to sign a Release of Information Authorization form. This form should be included in the client's case record. Situations which are exceptions and do not require a client's consent for disclosure of information are covered in Part 2.

4.7.2.5 REFERRALS FOR FAMILY MEMBERS OF ACTIVE DUTY PERSONNEL

Military family members seen at FSCs may be referred to community resources for clinical counseling assistance. TRICARE regulations recognize three levels of providers of clinical counseling services:

- Physicians and other allied health professionals **not requiring** physician referral and oversight:
  - Psychiatrist
  - Clinical Psychologist
  - Licensed Clinical Social Worker
  - Certified Psychiatric Nurse Specialist
  - Licensed Marriage and Family Therapist

- Extra-medical individual providers **requiring** physician referral and oversight:
  - Pastoral Counselor
  - Mental Health Counselor/Professional Counselor

FSC clinical providers must be cognizant of any TRICARE mental health pilot programs in their areas to ensure that clients are made aware of all options available to them via TRICARE regulations and initiatives. TRICARE guidelines must be followed to ensure that the TRICARE provider is eligible so that the TRICARE share of the client's clinical counseling costs will be covered. A strong liaison between the TRICARE office and the FSC is essential in order to provide the best services available to the clients.

4.7.2.6 ACTIVE DUTY REFERRALS

Service members requiring clinical counseling services which are outside the scope of FSC clinical practice and which are not available at the MTF may be referred to civilian outside providers through the MTF. The referral of active duty personnel for civilian care must be conducted by the local MTF. Supplemental care funds, administered by the local MTF, may be available to ensure access to specialty care **NOT** available at the MTF.

4.7.2.6.1 REFERRAL PROCEDURES FOR ALCOHOL TREATMENT

The Drug and Alcohol Program Advisor (DAPA) is an individual at each command who is tasked with the responsibility of assessing and appropriately referring individuals who may have issues with alcohol and drug abuse/misuse. The command DAPA's responsibilities are generally a collateral duty; the skills and the abilities of the DAPA

may vary from command to command. In 1996, the Alcohol Rehabilitation Centers were realigned under BUMED and became the Alcohol Rehabilitation Department (ARD).

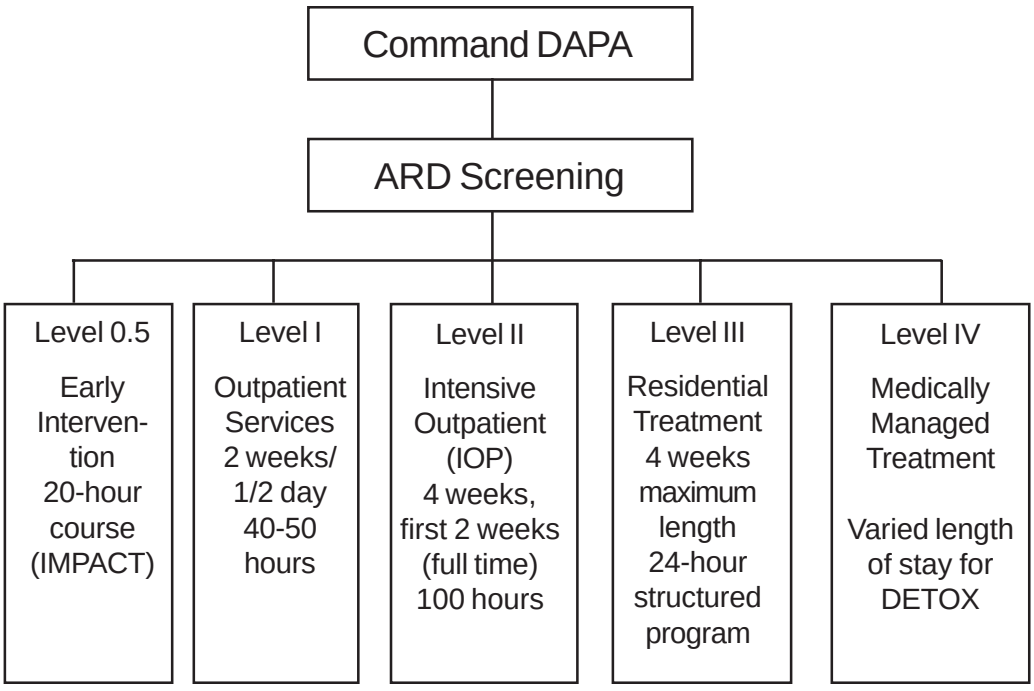
Active Duty Member

The following flow chart illustrates the various resources available within the Navy system to treat alcohol and drug abuse.

A screening will be done at ARD and the service member will be directed to the appropriate level of treatment. An aftercare program (one-year follow up) is available to both Level II and Level III participants. The DAPA is responsible for ensuring that aftercare occurs.

Family Program eligibility prioritizing (depending on availability) is as follows:

(1) Family members of those admitted to Level III.
(2) Active duty members who are co-dependents and/or ACOA.
(3) Family members of active duty military who are codependent and/or ACOA.



Family Member

TRICARE is available for coverage of family members of active duty military. Clients may be either alcoholic themselves or present with codependency issues. There are numerous treatment options, including inpatient, outpatient, group therapy, or partial hospitalization programs. Support group resources include:

- AA (Alcoholics Anonymous)
- Al-Anon
- ACOA (Adult Children of Alcoholics)
- Ala-Teen (Children of Alcoholics)
- CODA (Codependents Anonymous)

Each FSC should maintain a listing of community resources and practitioners with specialty areas. Each client should be evaluated on a case-by-case basis to determine which resources best fit the needs of the client.

4.8 CASE FOLLOW UP

4.8.1 DEFINITION AND PURPOSE

CASE FOLLOW-UP: A routine procedure for contacting a client, referral source, or service provider to determine client status. The purpose of this activity is to determine whether the intervention/treatment plan was appropriate for the client, whether the client followed through on the agreed upon goals and to what degree the outcome was successful.

4.8.2 GUIDELINES FOR CASE FOLLOW UP

FSC clinical providers handle a wide variety of situations, including information and referral, crisis intervention and short-term clinical counseling. The tasks involved in case follow-up depend on the identified needs of the client and may include:

- Contacting clients who were no shows/cancelled appointments.
- Coordinating referrals.
- Ensuring required reporting was done.
- Evaluating delivery of services during assessment/intervention stages.
- Updating the status on any tasks included in the intervention plan.
- Evaluating the effectiveness of a treatment plan.

- Requesting a progress report from a referral source/service provider.

These tasks can be completed by telephone or by mailing forms, letters, or checklists (Refer to Attachment 27 for Sample Client Follow-up form).

4.9 CASE CLOSURE

4.9.1 DEFINITION

CASE CLOSURE: A routine procedure for documenting results of clinical service delivery. There are clinical indicators that determine when it is appropriate to close a case:

- Client's presenting problem has been resolved.
- Treatment goals have been reached.
- Client or clinical provider wishes to terminate.
- A successful referral has been made and FSC services are no longer needed.

Non-independent FSC clinical providers will review cases with their Clinical Supervisor, who will provide input as to whether a case should be closed or remain open. If an "extension of services" is requested by the FSC clinical provider, it has to be approved by the Chief of Clinical Services depending on local FSC policy (Refer to Attachment 21 for Sample Case Closure form).

4.9.2 GUIDELINES FOR CASE CLOSURE

When closing a case, the case summary should include the following:

- Summary of services
- Summary of outcome
- Summary of prognosis
- Clinical provider's signature
- Supervisor review (staff who are privileged clinical practioners do not require supervisor review for case closure)
- Close QOLMISNET case record
- Note date of closure in Master Client Log

A case should be closed no later than 30 days after the date of the last client contact.

4.10 COORDINATION OF CASES IN COMPLEX SERVICE AREAS

4.10.1 DEFINITION

Coordination of cases in complex service areas refers to cases involving multiple service providers. Following is a case example:

After completing an assessment on a male, active duty client, the FSC clinical provider concludes that the client may have a mental disorder (i.e., a condition that falls outside of those diagnostic codes typically seen in an FSC) and refers him for a psychiatric evaluation. The evaluation results in a psychiatric diagnosis and it is recommended that he be discharged from the Navy. He is awaiting the results of a Medical Review Board, which will determine whether or not he is retained in the Navy. His wife has filed for divorce. She claims that he has physically and emotionally abused their two children and she is seeking custody of the children. They are also experiencing financial difficulties, having run up a large debt on their credit cards with no savings in the bank. The active duty member has no idea what kind of job he could work at if he is discharged from the Navy.

This case could involve the FSC clinical provider interfacing with the Psychiatry Department at the Naval Hospital, the Family Advocacy Program, the Department of Social Services (Child Protection Services Unit), civilian attorneys handling the divorce and custody actions, a financial counselor either at FSC or the local community, and the Transition Assistance Management Program (TAMP).

4.10.2 GUIDELINES FOR TRACKING COMPLEX CASES

The key to tracking complex cases is to document all contacts in an organized and consistent manner so the FSC clinical provider can keep track of who was contacted, when they were contacted, the method of contact, and the results of the contact. Outlining procedural guidelines and having policies in place to deal with a variety of case scenarios is essential in ensuring that important information will not slip through the cracks in a complex case. For example, all Memoranda of Understanding (MOU) that have been developed with community agencies (such as the local Police Department and the Department of Social Services Child Protection Services Unit) should be re-

viewed periodically to clarify whether they adequately cover situations that clients present when they seek assistance from FSC. A single point of contact (POC) should be designated at agencies that FSC clinical providers or the FSC Director work with on a consistent basis. This opens the door for FSC personnel to establish working relationships with community service providers and helps them to connect with the appropriate resources in a timely fashion (Refer to Attachment 28 for sample Case Tracking form).

PART FIVE:
Quality Assurance

5.1 DEFINITION AND PURPOSE

Quality Assurance refers to activities designed to:

- Assess services systematically,
- Determine whether they comply with identified quality indicators, and
- Correct any identified deficiencies.

Quality Assurance plans designed for human services program delivery should include the following:

- Analysis of quality of service delivery through reliance on client feedback, supervisory observations, and quantitative and qualitative evaluation methods.
- Identification of deficiencies and development of correction plans of action.
- Ongoing client needs assessment to develop responsive programs and services.
- Cost-effectiveness control procedures to prevent overutilization and to ensure that needed services are provided in a timely and efficient manner.

The Navy Family Service Center (FSC) Accreditation Quality Standards evaluation system is a comprehensive process for monitoring and evaluating FSC programs. Accreditation reflects achievement of excellence gained through continuous quality improvement. The extensive accreditation system which is based on the Quality Standards includes:

- A system-wide standard of excellence for FSC services.
- A defined scope of FSC services.
- An established baseline for FSC customer expectations.

The Accreditation Quality Standards should be used independently of the accreditation process:

- As a self-assessment tool.
- As a training guide.
- A basis for FSC ongoing evaluation.
- A validation tool for FSC resource requirements.

DODINST 1342.22 requires implementation of a comprehensive evaluation system to measure the effectiveness and impact of FSCs. It includes establishment of servicewide measurement criteria for monitoring and evaluating FSC programs through triennial inspections. This policy statement established FSC Accreditation and related implementation of quality standards. The accreditation process and quality standards were designed by quality standards working groups that met in 1991 and 1992. Membership included PERS staff, claimant, and field site representatives from the FSCs. Consultation and training was provided by the Council on Accreditation of Services for Families and Children, a leading agency in the accreditation of social service programs. The information contained in the *Clinical Counseling Desk Guide* reflects the 1999 revisions to the Accreditation Quality Standards.

5.2 ELEMENTS OF A QUALITY ASSURANCE PLAN

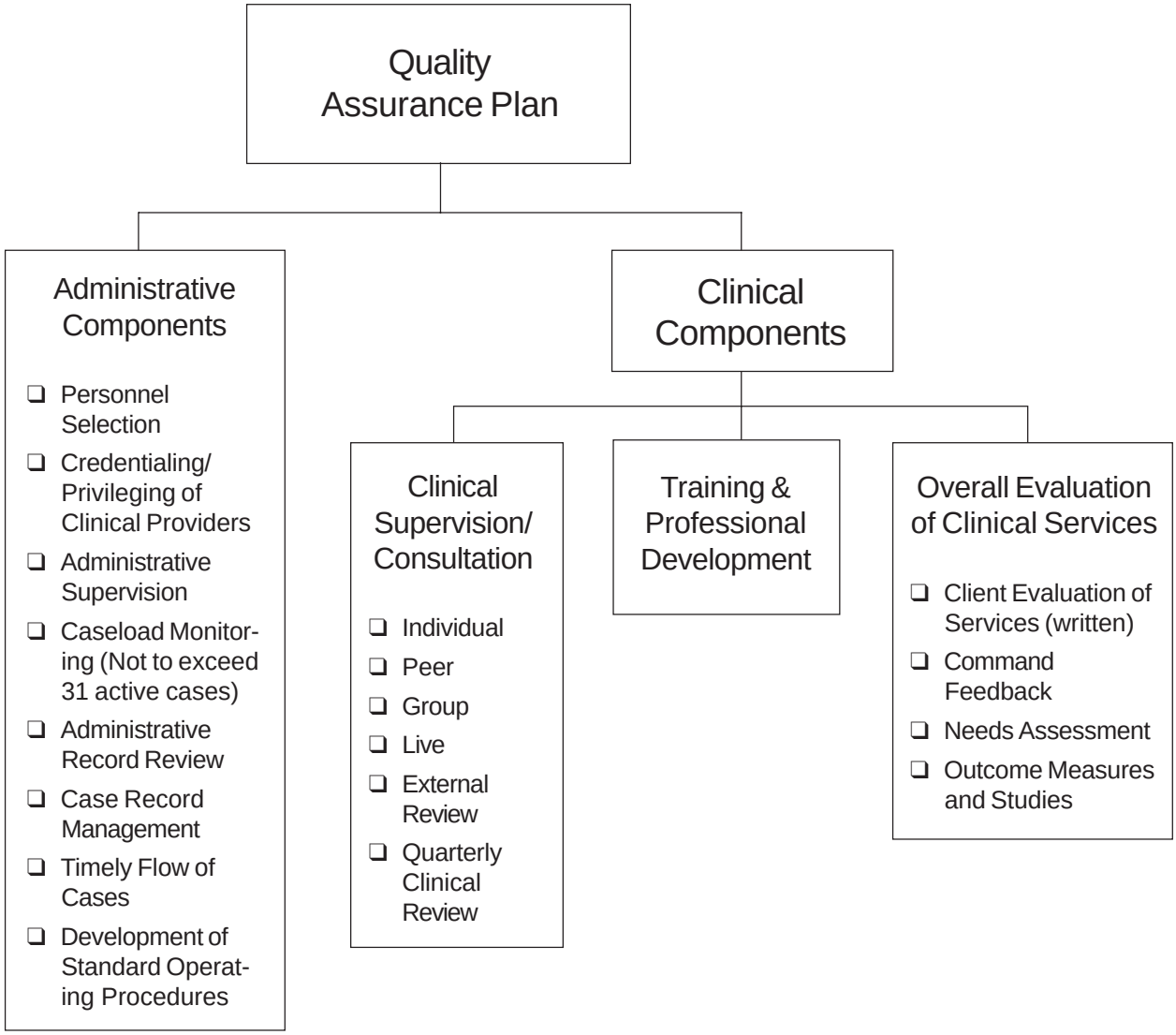
A comprehensive Quality Assurance (QA) Plan for FSC clinical counseling services integrates and operationalizes the FSC Accreditation Quality Standards and Accreditation system. FSCs Accreditation Quality Standards include functional area quality standards related to clinical counseling service delivery.

The primary purpose of the QA Plan for clinical counseling services is to ensure the provision of the highest caliber clinical counseling services to the Navy community. A comprehensive QA Plan will include measures to ensure appropriate, equitable, and quality clinical services are provided to FSC clients. The overall objectives are to:

- Ensure clients receive appropriate services in a timely and responsive manner.
- Detect and correct deficiencies in service delivery.
- Ensure full compliance with FSC Accreditation Quality Standards.

A functional QA Plan for clinical counseling services will establish and delineate structured management approaches and tools which will assist the FSC Chief of Clinical Services in ensuring client needs are met and that service delivery conforms with FSC Accreditation Quality Standards.

5.2.1 QUALITY ASSURANCE PLAN COMPONENTS



5.3 COMPONENTS OF AN ADMINISTRATIVE QUALITY ASSURANCE PLAN

5.3.1 PERSONNEL SELECTION

At most FSC sites, the FSC Director is responsible for ensuring that all clinical counseling personnel and clinical counseling supervisors are in compliance with the requirements specified in SECNAVINST 1754.7, Credentials Review and Clinical Privileging of Practitioners/Providers in DoN FSCs, which specifies education, training, practice requirements, and credentialing of FSC clinical providers. At sites with FSC contract personnel, the senior contract staff member on site and clinical supervisors are responsible for selecting and hiring personnel in compliance with SECNAVINST 1754.7. Generally, the Contracting Officer's Representative (COR) has ultimate approval authority of recommended contract staff and must ensure the selection and placement of qualified personnel. Careful personnel selection and screening helps to ensure a well-qualified, trained, and professional staff. Whether the FSC is civil service or a contract site, the following guidelines should be used when hiring clinical counseling staff:

- **Educational background:** Official copies of all graduate transcripts. Effort should be made to insure that the applicant's degree is from an institution accredited by his/her profession's respective accrediting body (e.g., Council on Social Work Education for social workers). If a clinical provider's degree is not from an accredited program, expert evaluation of transcripts to determine equivalence to accreditation standards will be conducted by PERS-66.
- **Professional Credentials:** Copies of: (a) all current licenses/certifications issued by a state or U.S. territory, (b) all current national certifications, and (c) affidavits of clinical supervision received after the graduate degree. (NOTE: Primary source verification of required credentials is conducted by PERS-66 for federal employees and by contractors for their own employees).
- **Former employers:** Inquiries should be made regarding the applicant's job performance, client complaints or any allegations of unethical conduct.

If possible, a provider's credentials (i.e.., their Individual Credentials File (ICF) or Individual Professional File (IPF)) should be forwarded to the Centralized Credentials Database (CCDB) at PERS-66 for review and privileging recommendation prior to, or as soon as, he/she report for duty. All clinical practice by newly hired providers must be supervised until they are privileged as independent practitioners.

5.3.1.1 BACKGROUND CHECKS FOR FSC CLINICAL PROVIDERS

In accordance with DoDINST 1402.5, background checks are required for all civilian FSC staff, including non-clinical staff who have direct contact with children in the performance of their duties. The scope of the background check includes:

- A national agency check with inquiries (NACI);
- State criminal history repository (SCHR) background checks;
- An installation records check (IRC).

FSC staff may be permitted to work prior to completion of the background check provided the employee is within the line-of-sight of an employee whose background checks have been completed. For example, a new clinical provider who is awaiting their background checks may function as a co-therapist in a children's group but they cannot see any children independently.

It is the FSC Director's responsibility to ensure that all necessary background checks are completed and forwarded at the time of hiring or at the time that the employee's responsibilities are changed to include child contact. The Contracting Officer's Representative (COR) will assist in ensuring background checks are completed for all contract employees. Background check working files and background summary records must be maintained in accordance with DoDINST 1402.5.

5.3.1.2 STANDARDS OF CONDUCT

The Standards of Conduct provide a code of ethical behavior designed to ensure the integrity of the Navy and its personnel. The Guidance Memorandum: Family Service Center Staff Training, Confidentiality and Referral Procedures provides additional guidance regarding Standards of Conduct within FSCs as they relate to the referral of clients to outside providers. These guidelines are summarized in Section 5.3.1.2.1. The examples given are not all encompassing but rather describe the most commonly encountered situations. The FSC Director and FSC staff must be familiar with the Standards of Conduct in the event that certain client referrals come into question. Strict adherence to the Standards of Conduct should not in any way hinder the delivery of responsible care for clients.

NAVAL PERSONNEL SHALL AVOID ANY ACTION WHICH MIGHT RESULT IN OR

REASONABLY BE EXPECTED TO CREATE THE APPEARANCE OF USING PUBLIC OFFICE FOR PRIVATE GAIN.

FSC personnel shall not refer clients to facilities where the same employee maintains off-duty employment. In particular, FSC employees engaged in off-duty employment may not solicit or accept compensation, directly or indirectly, for care rendered to any DoN beneficiary entitled to care. In fact, TRICARE payments may be disallowed in any claim from a TRICARE provider in those instances when a FSC employee renders service to an entitled DoN beneficiary.

NAVAL PERSONNEL SHALL AVOID ANY ACTION WHICH MIGHT RESULT IN OR REASONABLY BE EXPECTED TO CREATE THE APPEARANCE OF GIVING PREFERENTIAL TREATMENT TO ANY PERSON OR ENTITY.

FSC personnel shall avoid the appearance of giving preferential treatment to any person or entity. For example, all referrals should be made strictly on the basis of professional merit, without favoritism toward organizations employing current or former FSC employees. Consideration should be given to making referrals in a manner which will create the widest possible base for future referrals. An FSC employee may refer to an agency where another FSC employee has off-duty employment. It would, however, be improper for the FSC employee to see the client while working at the outside agency. It would also be improper to refer clients to any outside agency where an FSC employee has proprietary interests, is a partner, owner, or coowner of the agency.

NAVAL PERSONNEL SHALL NOT ACCEPT GRATUITIES FROM ANY DEFENSE CONTRACTOR OR ANY INDIVIDUAL OR ENTITY SEEKING TO DO BUSINESS WITH DoN.

FSC personnel are prohibited from accepting gratuities from anyone, including former FSC employees who are seeking business with the FSC or to whom future referrals could be made. A gratuity is defined as a personal favor or gift given to an individual. Therefore, the prohibition on gratuities would not apply to in-service training provided by outside professionals.

NAVAL PERSONNEL CANNOT USE INSIDE INFORMATION TO FURTHER A PRIVATE GAIN.

Both current and former FSC personnel are prohibited from using information acquired by reason of their FSC employment to induce any referral to either themselves or their off-duty employer.

NAVAL PERSONNEL MUST AVOID OUTSIDE EMPLOYMENT OR ACTIVITY WHICH IS INCOMPATIBLE WITH OFFICIAL DUTIES OR MAY BRING DISCREDIT TO THE NAVY.

FSC personnel are subject to several constraints on off-duty employment. FSC employees should be available to provide services to military beneficiaries at all times during their prescribed working hours. Off-duty commitments may not interfere with these duties. Furthermore, FSC employees desiring to engage in off-duty employment, where DoN personnel may be referred, shall obtain the written permission of the FSC Director prior to such employment. In making such determination, the FSC Director will consider whether the outside activity (1) interferes with or is not compatible with the performance of Government duties; (2) may reasonably be expected to bring discredit upon the Government or the Department of the Navy; or (3) is otherwise inconsistent with the requirement to avoid actions and situations which reasonably can be expected to create a conflict of interest.

5.3.1.2.1 STANDARDS OF CONDUCT STATEMENT

All FSC clinical providers should read the Standards of Conduct statement and document that they agree to comply with the standards while employed at the FSC. Refer to the following sample form.

FAMILY SERVICE CENTER
STATEMENT OF STANDARDS OF CONDUCT

I, _____, have reviewed and agree to comply with the Navy Standards of Conduct while employed at the FSC. I understand that I am not to engage in private practice with individuals who are eligible for TRICARE or are eligible for services in a military setting.

_____ _____
Employee Date

_____ _____
Supervisor Date

5.3.2 CLINICAL COUNSELING INTERNS

The following steps should be followed for the placement of clinical counseling interns:

Step 1: **FSC Clinical Supervisor; Questions to consider:**

- What kind of involvement will the intern have with clients (i.e., will information and referral be over the phone or in person; individual clinical counseling; group clinical counseling, etc.)?
- What is the screening process conducted by the university for these interns?
- What education/training is required prior to placing an intern at the FSC? It is recommended that only second year (or higher) Master's level or Doctoral program interns be considered for placement for an intern for the clinical counseling unit.
- What is the supervision plan for these interns?

Step 2: Determine the level of client involvement.
The scope of services provided by the intern must be closely monitored (i.e., interns may be initially used as intake workers under close monitoring and supervision and then transition to doing short-term individual clinical counseling).

Step 3: Develop an internal management plan for interns.
- Develop an FSC policy with regard to interns providing clinical counseling services; consult the installation legal officer.
- Initiate screening/placement policies and procedures for interns who provide clinical counseling services.
- If interns will be providing clinical counseling services to children, they must complete a Criminal History Background Check (CHBC) in compliance with the Crime Control Prevention Act.
  - Check state/central child abuse registries
  - Ask NCIS to conduct a background, criminal records check
- Educate the FSC staff regarding risk management.
- Develop an attitude of staff accountability.

Step 4: Provide ongoing management and supervision.
- Provide regular supervision and training.
- Deal with any mistakes forthrightly.
- Immediately inform FSC Director, university field director, and chain of command as appropriate.
- Do not try to cover up or minimize a problem. The well-being of clients, who are in a vulnerable position when they seek assistance from FSC, is at risk. Minimal damage can often be remedied; long-term damage may be irreversible.

5.3.3 CREDENTIALING OF FSC CLINICAL PROVIDERS

Credential standards for FSC clinical providers are contained in:

(a) DoD 6400.1-M: FAMILY ADVOCACY PROGRAM STANDARDS AND SELF-ASSESSMENT TOOL

(b) SECNAVINST 6320.23: CREDENTIALS REVIEW AND CLINICAL PRIVILEGING OF HEALTH CARE PROVIDERS

(c) SECNAVINST 1754.7: CREDENTIALS REVIEW AND CLINICAL PRIVILEGING OF

CLINICAL PRACTITIONERS/PROVIDERS IN DEPARTMENT OF THE NAVY (DoN) FAMILY SERVICE CENTERS.

(d) BUMEDINST 6320.66A: CREDENTIALS REVIEW AND PRIVILEGING PROGRAM

Credentials are demonstrated by a combination of education, professional experience, and supervised experience. SECNAVINST 1754.7 categorizes clinical care provider functions into three distinct Tiers of professional qualification.

a. Tier I includes entry level providers who are collecting their supervised clinical hours to be applied toward licensure. Licensure/certification shall be completed within a 36-month period. Exceptions to this policy must be approved by CHNAVPERS/CMC-MR. These providers, who are not privileged to provide independent clinical care, must perform all clinical duties under the supervision of a licensed practitioner and under no circumstances can provide independent clinical care. SECNAVINST 1754.7 (Enclosure 4) provides details concerning the limits of practice for non-privileged providers. No more than one-third of the clinical counseling staff should be a Tier I provider as a general guideline. All Tier I providers will receive on-going clinical supervision toward licensure by a Tier III Clinical Supervisor.

b. Tier II includes providers who are state licensed or state certified (or were granted a license or a certificate by a U.S. territory) to provide independent clinical care. These providers are eligible to apply for clinical privileges to function as an independent practitioner.

c. Tier III includes providers who are state licensed or state certified (or were granted a license or a certificate by a U.S. territory), have been granted clinical privileges to function as an independent practitioner and have attained specified additional clinical experience. Clinical supervision of other FSC or FAP Center providers and the ability to function as a sole provider (often in remote locations) is restricted to providers who are qualified in Tier III. This three-tier model is designed to ensure quality clinical care delivery of services and to serve as a career path for Family Service Center and Family Advocacy Center clinical providers.

d. Practitioners functioning in Tiers II and III must possess a current, valid, unrestricted license or certification which grants independent status, per SECNAVINST 1754.7, to be eligible for professional staff appointment with clinical privileges. Current practice groups that are eligible for clinical privileging (i.e., Tiers II or III) are: Psychologists, Social Workers, and Marriage and Family Therapists.

5.3.3.1 CREDENTIALING POLICY, REVIEW, AND PRIVILEGING OF FSC CLINICAL PROVIDERS

General Information

- SECNAVINST 1754.7 establishes the policies and minimum standards for credentials review and clinical privileging of FSC and FAP Center clinical providers.

Policy

- FSC and FAP Center clinical counseling is by design multidisciplinary. Clinical counseling services offered by FSCs and FAP centers meet a basic need for clinical counseling and reduce the costs associated with referrals to private social service providers. In order to achieve quality standards of clinical services in FSCs and FAP centers, clinical providers will function within a three-tier system of professional qualifications in the provision of clinical services. The provisions of clinical services provided at FSCs and FAP centers will be consistent with staff resources, scope of practice, quality assurance procedures and guidance contained herein.
- Clinical counseling provided in FSCs and FAP Centers is intended to be problem focused and "brief". "Brief treatment" is not specifically defined in terms of an absolute number of sessions nor for a finite time period. The intent is to focus clinical counseling on well defined problem areas amenable to relatively brief intervention/treatment. Clinical providers shall possess the clinical expertise to assess disorders contained in the standard nomenclature of the DSM, for the purposes of appropriate referral and quality client service.
- A centralized credentials database (CCDB) will be maintained at Naval Personnel Command (PERS-66). In FSCs and FAP Centers, clinical practitioners include: Psychologists, Social Workers, and Marriage and Family Therapists. Practice groups eligible for independent privileging are consistent with the current federal regulation (e.g. 32CFR199.6 and 42CFR5).

Record Review & Quality Assurance

- *Records Audit.* The FSC/FAP Center Director is responsible for ensuring the audit of FSC/FAP files to ensure all required documentation is present, complete, and conducted in a timely manner. Audits shall not involve the reading or critique of clinical assessments, case notes, or treatment plans. Records will be selected randomly and audits conducted on a quarterly basis. Results and follow up actions will be documented in the "Records Audit" section of the Quality Assurance file.

- *Clinical Care Review*. A clinically privileged practitioner is responsible for the clinical case review. The review consists of a review of clinical records to ensure the appropriateness of initial assessment, case notes, treatment plans, referrals and recommendations for the termination of treatment. The review is conducted on a quarterly basis for all clinically privileged practitioners and will include a random sample of 10% of cases opened that quarter and 5% of records closed that quarter for each clinical privileged practitioner. All (100%) records are reviewed by the Clinical Supervisor for non-privileged clinical providers.
- *Supervision/Consultation.* All FSC and FAP Center clinical providers will participate in clinical supervision or consultation depending upon their privileging status.
- *Client Satisfaction.* Surveys will be conducted to evaluate the quality of FSC and FAP Center care. Both clients and Commands will be surveyed. Results shall be analyzed on at least semiannual basis and incorporated into the Center QA files.
- *Critical Incident Review.* Installation commander (or designee) will convene locally established critical incident review committee to review any allegations of unethical behavior, life endangering incidents, and/or allegations of deviance from accepted practices. If a critical incident review committee recommends a change in a clinical provider's privileges or a termination of professional staff appointment, a Peer Review Panel shall be established. (Refer to SECNAVINST 1754.7, Enclosure 5)
- *Confidentiality.* FSCs, FAP Centers, and commands shall ensure compliance with the Privacy Act of 1974, SECNAVINST 5211.5D, and 10 U.S.C. 1102 with respect to client records and provider/practitioner records.
- *Referral to outside sources:* Individual family members seen at FSCs and FAP Centers maybe referred to community resources for clinical counseling and or other assistance. In such cases, adequacy of care provided by the referral source must be evaluated in accordance with service specific guidance and local protocols.

Clinical Privileges

- Clinical privileges are the type of practice activities permitted within defined limits based on the practitioner's education, ability and judgement. Standardized privileges for all clinical staff are consultation, differential diagnosis, and treatment planning. On the following page is a chart of diagnostic and therapeutic procedures for Clinical Psychologists, Clinical Social Workers, and Marriage and Family Therapists in FSCs.

CLINICAL PRIVILEGES

PRIVILEGES	APPLICABILITY TO SERVICE PROVIDERS		
Diagnostic/ Therapeutic Procedures	**Clinical Psychologists**	**Clinical Social Workers**	**Marriage and Family Therapists**
Interviewing	◆	◆	◆
Major types of psychotherapy including short term, family, marital, group, individual, and behavior therapy	◆	◆	◆
Community Outreach & Systemic Consultation	◆	◆	◆
Mental Status Examination	◆	◆	◆
Crisis Intervention	◆	◆	◆
Case Management (Family and Individual)	◆	◆	◆
Psychosocial History Taking	◆	◆	◆
Special Psychological Examinations	◆		
Administration and Interpretation of Psychological Tests	◆		

Delineation of Privileges:
Clinical privileges are given to the individual by the Chief of Naval Personnel (CHNAVPERS) or designee, following application review and completion of a satisfactory provisional period. Assignment of clinical privileges will be based on demonstrated education, training, experience and competence.

Evaluation of Privileges:
Designated privileging authorities will maintain an Individual Credentials File (ICF) on all privileged clinical practitioners. Designated credentialing authorities will also maintain an Individual Professional File (IPF) on all non-privileged clinical providers. Contractors will maintain a current ICF/IPF for their employees working within FSCs and FAP Centers and will provide a copy to the designated privileging authority. The ICF/IPF will contain documentation related to the clinical provider's current and past licensure/certification status, education and training, professional experience, current competence and other items listed in SECNAVINST 1754.7 in accordance with service specific guidance. Commanding officers must ensure the information contained in the ICFs/IPF is monitored, continually updated, and reported quarterly. Commanding officers must also ensure full compliance with all requirements relating to Quality Assurance and 10 U.S.C 1102. The ICF/IPF will be transferred with the providers through their course of DON employment or archived upon their departure from DON employment.

5.3.4 CLINICAL PROVIDER CASELOAD

To ensure that clients are receiving high-quality clinical counseling services when they seek assistance from FSC, one of the most important areas to monitor is clinical provider caseload. There are factors which can be utilized in defining a clinical provider's caseload:

(1) Is the FSC able to provide clinical counseling services for all clients who request it, or is it necessary to prioritize client requests for services? This determines the profile of the clinical provider's caseload (i.e., what percentage is active duty personnel; are they spouses and/or children of active duty personnel, etc.),

(2) The amount of time a clinical provider is expected to provide clinical services during a defined time period is a factor that affects caseload size. This also factors in to how many sessions a clinical provider can see a client, whether a clinical

provider can facilitate groups, and the degree of participation a clinical provider can have in conducting educational presentations and command briefings.

These factors vary among FSCs worldwide because each FSC is unique. As per Accreditation Quality Standards, a clinical provider's active case load will average 31 cases when the clinical provider is engaged in direct clinical service delivery 100 percent of the time. For example, a clinical provider working at an FSC in an overseas location may carry a caseload of 31 clients, in which 10 are children, 11 are family members, 7 are active duty personnel, and 3 are DoD government employees. Another clinical provider working at an FSC in a large fleet concentration area may have a caseload of 25 clients, in which all are active duty personnel. A 1:31 clinical provider to caseload ratio is the expectation for clinical providers for whom 100 percent of the workload is direct clinical service delivery.

Why is there such a disparity in caseload composition and size? This is the result of the wide range of variables that must be taken into consideration when determining the parameters of an FSC clinical provider's caseload. These variables include the following:

- **Position Description**
  The individual clinical provider's position description may designate the percentage of time spent providing clinical counseling services and other types of services (i.e., facilitating groups and presenting educational programs). The position description should also include a statement about minimum professional credentials and privileges required for the position.

- **Size of Clinical Provider Staff**
  Have there been recent cutbacks in staff or vacant positions that remain unfilled due to a hiring freeze or other reasons?

- **Clinical Provider's Level of Experience**
  Is the clinical provider credentialed? A recent graduate with minimal experience? Does the clinical provider have knowledge of the military system and/or experience working with military families?

- **Client Demand for Services**
  Who is requesting clinical counseling services? Are they active duty members, spouses/children of active duty members, retired personnel, government employ-

ees, active duty personnel from branches of the service other than the Navy? What percentage of these individuals can be referred to other resources? What percentage are active duty members who have limited and/or no other options? How many individuals are on the waiting list for clinical counseling services?

- **Available Resources in the Civilian Community**
  What is the availability of community resources and TRICARE-approved providers in the local civilian community? Is this FSC located overseas or in a geographically isolated location in CONUS where there are limited resources and/or the FSC is the only resource for active duty members and their families who seek clinical counseling?

- **Local Conditions**
  Are there unique conditions existing at certain locations that have an impact on the quality of life for individuals stationed there and result in an increased number of people seeking clinical counseling services (e.g., extreme weather conditions, limited hours of daylight, water/electricity shortages, geographical isolation, cultural biases)?

- **Military Population**
  What are the demographics of the military population who are the target group for clinical counseling services? Are they predominantly enlisted, officers, or a combination of both? Are they young service members right out of boot camp or an older population with more seniority?

- **Military Mission**
  What are the missions of the commands that the FSC serves? Are they predominantly deploying units? Are they surface or air? Do their jobs have a high degree of danger and secretiveness? Are they operational commands or support staff? Are they high-visibility or low-visibility commands?

- **Cyclical Patterns**
  Does caseload composition and size vary considerably depending on certain events that occur regularly, such as the deployment and return of military units and the transfer season when people are arriving and departing from the duty station?

- **Complexity of Cases**
  What kind of problems are clients seeking assistance for at the FSC? Do these problems require more than a few sessions with a clinical provider? Are there

providers in the civilian community who specialize in the identified problem area and is it realistic for the client to receive services from this provider? Will group clinical counseling meet the needs of some of these clients and does the FSC have the staff available to facilitate such a group?

It is not the intent of the *Clinical Counseling Desk Guide* to make a determination on the caseload size for every FSC clinical provider worldwide but to provide guidelines. Each agency is expected to make that determination on the basis of the factors described previously. Selecting an arbitrary number of cases which is appropriate for each and every clinical provider to carry would serve no positive purpose. The same is true for clinical providers working at FSCs worldwide.

When a sample of FSC Chiefs of Clinical Services were consulted about caseload size, they indicated that a range of between 25 to 30 cases per clinical provider would be considered an ideal caseload size; and approximately 50 percent of a clinical provider's time would be spent in the provision of direct clinical counseling services. The maximum ongoing, active caseload of an FSC clinical provider should average 31 active cases when the clinical provider is engaged in direct clinical service delivery 100 percent of the time. The variables listed previously should be the determining factors in whether an FSC clinical provider is at the low end of the spectrum (20 cases) or the upper end (30 cases).

Chiefs of Clinical Services or FSC Directors with clinical responsibilities are responsible for monitoring clinical provider caseload size to ensure that clinical provider caseloads are manageable and clients receive the best quality services the FSC can provide.

5.3.5 CASE RECORDS

5.3.5.1 RECORD REVIEW

ADMINISTRATIVE RECORD REVIEW: The FSC Director is responsible for administrative review of FSC clinical counseling records. OPNAVINST 1754.1A and SECNAVINST 1754.7 requires quarterly review of these records to ensure the following: there is a signed and witnessed Privacy Act Statement; signed and witnessed client's rights and responsibilities; client information face sheet (QOLMISNET information); session notes are being kept properly; there is special handling of Personal

Reliability Program/special security clearance clients; thorough documentation of proper referral, and so forth. The administrative review should be conducted on a random, spot-check basis for at least 10 percent of all cases (Refer to Attachment 29, 30 and 31 for sample review forms) and should occur, at a minimum, quarterly.

CLINICAL CARE REVIEW: The Chief of Clinical Services is responsible for providing general quality assurance by overseeing clinical care review of all clinical practitioners. This review will be done only by clinically privileged practitioners to ensure the appropriateness of initial assessment, case notes, treatment plans, referrals and recommendations for termination of treatment. Clinical care review will be conducted on a quarterly basis and include a random sample of 10% of open cases and 5% of closed cases for each practitioner that quarter. The records of non-privileged clinical providers are subjected to 100% clinical care review by the provider's clinical supervisor.

5.3.6 RECORDS MANAGEMENT

5.3.6.1 ACCESS TO RECORDS

Clinical counseling records are to be maintained in a manner consistent with the Privacy Act (Refer to Section 2.2). Only authorized staff members will handle case record materials. Authorized FSC staff members include:

- Clinical Counseling Supervisor/Chief of Clinical Services
- Clinical Providers
- Designated Administrative Personnel
- FSC Director
- Personnel entering case record material on data processing equipment for electronic storage

Case records may be removed from the FSC premises only with the consent of the FSC Director and/or Chief of Clinical Services. Case record removal will be approved only for official purposes, such as a court subpoena or request from the FAP Case Review Committee. If the FSC Director or Chief of Clinical Services checks out a record, the other approval source must also grant check-out approval.

5.3.6.2 STORING & DESTROYING CLOSED CASE RECORDS

Closed clinical case records should be placed in locked storage for a period of 2 years following last contact and closure, then destroyed. Electronic records are maintained for a period of five years and then destroyed. Designated administrative personnel should destroy paper records in a burn bag or shredder. Magnetic records can be erased or degaussed.

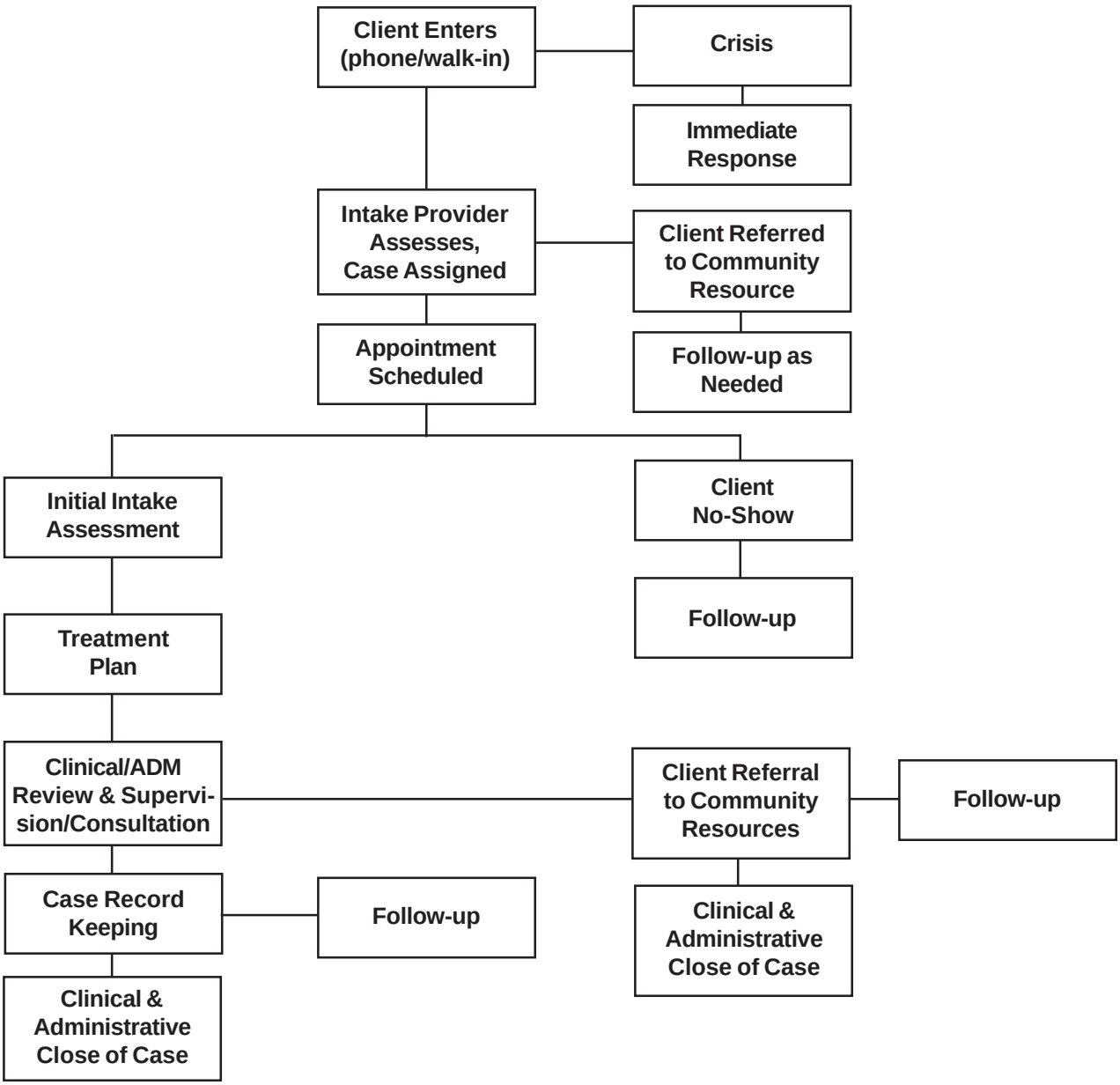
5.3.6.3 MASTER CLIENT LOG AND INTAKE REFERRAL LOG

Administrative tracking of FSC clients is important to ensure appropriate services are provided. The Intake Referral Log and Intake Sheets should be reviewed and initialed monthly by the Chief of Clinical Services for assessment of services rendered, appropriateness of referrals, and completion of follow-up measures. The Master Client Log should also be monitored to track caseload, timely flow of cases, and timely purging of records (Refer to Attachment 12 for sample format).

5.3.7 TIMELY FLOW OF CASES

It is the responsibility of the Chief of Clinical Services to monitor the length of time clinical providers are providing clinical counseling services to clients. The administrative support staff can provide relevant information to the Chief of Clinical Services on a monthly basis (i.e., number of cases currently open) to provide the Chief of Clinical Services with an accurate picture of service delivery at the FSC. Although the number of sessions a clinical provider will see clients is not standardized for FSCs worldwide (Refer to Section 1.9.3), FSCs should require that clinical providers submit an "Extension of Services" request form if their assessment indicates clients need to continue beyond the number of sessions which have been defined at their FSC as short-term clinical counseling. The request form should be submitted to the Chief of Clinical Services who determines whether the extension of services is clinically appropriate for the case. If the Chief of Clinical Services approves the request, generally it is then submitted to the FSC Director for final approval (Refer to Attachment 32 for sample form).

5.3.7.1 CASE FLOWCHART



5.3.8 QUALITY ASSURANCE MONITORING METHODS

The same measures should be used to assess quality assurance practices within the administrative component of the QA plan for Clinical Counseling Services which were used in the clinical component—supervision, training, and evaluation. These measures can be used on an ongoing basis to ensure quality services are being delivered:

- **Client Satisfaction**
  As per SECNAVINST 1754.7 client satisfaction surveys will be conducted to evaluate the quality of FSC clinical counseling services. Both client and command satisfaction survey data should be collected. Results should be compiled and analyzed on at least a semiannual basis and incorporated into the FSC QA files (Refer to Attachment 33 for sample).

- **Supervision**
  The implementation of QA standards and practices should be discussed on a regular basis in supervision with staff who are responsible for the administrative component of the QA plan for Clinical Counseling Services. These staff members can include the designated administrative personnel, Administrative Services Supervisor, Chief of Counseling Services, and Director, depending on how the FSC has designed its QA plan (Refer to Section 5.4.1, Case Supervision).

- **Training**
  Initial training is received when a staff member is new on the job and is required to learn about QA practices and how they are implemented at the FSC. However, additional training should be scheduled at regular intervals to reinforce skills already in practice and to update staff on new techniques.

- **Evaluation**
  Part of staff's performance evaluations should be based on how effectively they are implementing QA practices which have been designated as part of their overall job responsibilities. An evaluation of the overall QA Plan for Clinical Counseling Services should include ongoing evaluation activities as staff and supervisors examine new and better ways to ensure FSC clients receive quality clinical counseling services.

5.3.9 STANDARD OPERATING PROCEDURES (SOPS)

An integral part of the clinical counseling unit's overall QA Plan is the development and utilization of SOPs, which outline standard practices and requirements for service delivery. The *Clinical Counseling Desk Guide* provides direction for development of local SOPs. The information presented below specifies the minimum SOPs which must be developed and used by each respective clinical counseling services unit. Each locally developed SOP must be revised and updated no less than once a year.

RECOMMENDED SOPs

- Confidentiality
- Clinical Case Record Management
- Family Advocacy Program
- Access to Case Records and Removal of Records from the FSC
- Urgent Cases/Command Referrals
- Counseling Division Policies
- Policy for Handling Allegations of Unethical Behavior
- Duration of Clinical Counseling Services
- Clinical Counseling Supervision

5.3.10 CLINICAL COUNSELING SERVICES MANUAL: SAMPLE TABLE OF CONTENTS

It is recommended each FSC develop its own local Clinical Counseling Services Manual, developed in accordance with the Accreditation Quality Standards. Local SOPs would be in one central location along with pertinent instructions and local resources. The *Clinical Counseling Desk Guide* should be the primary resource tool for the development of the local Clinical Counseling Services Manual. A sample of suggested content is listed here:

- Preface or Introduction to the manual
- Orientation Overview (for new staff)
- Intake Screening SOP

- Clinical Case Record Management SOP
- Referrals and Required Reporting SOP
- FAP Referral SOP
- Alcohol/Drug Referral SOP
- Crisis Intervention: Suicide/Homicide SOPs/Urgent Command Referrals
- Confidentiality SOP
- Quality Assurance SOP
- Student Interns SOP
- Pertinent FSC Instructions
- Guidance Memorandum
- State Codes for Child Abuse and Neglect and Domestic Violence
- Clinical Counseling Accreditation Quality Standards

5.4 COMPONENTS OF A CLINICAL QUALITY ASSURANCE PLAN

5.4.1 CASE SUPERVISION

The supervisory responsibilities of the Chief of Clinical Services at a FSC are twofold. The responsibilities include oversight of case management and of clinical supervision of the staff. Although these two areas have some overlap, some of the required tasks necessary to accomplish the goals of each one are different. Case management should not in and of itself be interpreted as fulfilling the requirements for oversight of staff clinical supervision. The following sections delineate the differences in case management and clinical supervision.

5.4.1.1 CASE CONSULTATION

Case consultation generally involves a regularly scheduled meeting of the Chief of Clinical Services and all clinical providers. The format varies from one FSC to another. A sample FSC format is outlined:

Three-Tier Case Management
Chief of Clinical Services and clinical providers meet once weekly for a specified period of time, and discuss the following:

1. **Intake Services:**
   Cases are staffed weekly. The clinical provider who handled the intake/screening describes the case and makes recommendations. Cases are prioritized (critical, waiting list, seen at FSC, referred out).
2. **Case Review:**
   New cases are presented (presenting problem, assessment, treatment plan)
3. **Case Conference:**
   Each week a different clinical provider presents an in-depth case review.

Because each FSC is unique in terms of staff size, client demand, and case profiles, the format and time frame of case review sessions will vary. Regardless of the format, a regularly scheduled case review meeting is essential to accomplish the following:

- Allow the Chief of Clinical Services to monitor the types of cases coming into FSC.
- Allow the Chief of Clinical Services to observe clinical provider's level of clinical expertise.
- Assist clinical providers in developing appropriate treatment plans.
- Provide an opportunity to enhance clinical provider's clinical skills by exposing them to a wide range of cases and clinical orientations.

5.4.1.2 PEER REVIEW

Peer review is a method of supervision in which clinical providers within the FSC meet regularly to review cases and treatment approaches. The benefits of peer review are many, including sharing expertise and enhancing the professional development of all clinical providers within the FSC.

The group has control of the meetings; the Chief of Clinical Services/Clinical Supervisor, participates as another member of the group. Peer supervision is a good adjunct method of case review to use, particularly when some of the clinical staff are working toward licensure. It provides additional exposure to a wide range of cases and clinical interpretations in a different context than the supervisor/clinical provider one. It also allows the more experienced clinical providers to share their clinical expertise with their less experienced coworkers.

Many resources are available which discuss the advantages of peer review, such as Haley, Learning and Teaching Therapy, 1996 and Shulman, Interactional Supervision, 1994.

5.4.1.3 EXTERNAL REVIEW

Whenever it is feasible, invite an experienced clinician to the FSC on a consultant basis to assist in reviewing. This process could include an independent clinical provider such as a privileged social worker, psychologist, or psychiatrist from the Naval Hospital or local mental health community or a Naval reservist with the appropriate credentials. This person may be consulted on complex cases; cases that involve a certain population (children, AMAC, etc.) in which the clinician specializes; or on a wide range of cases. How this individual assists in the case review process depends on who is being asked to provide the service, his or her training and area or areas of expertise, when the person is available, and the local needs of the FSC.

5.4.1.4 STAFF SUPERVISION

In accordance with SECNAVINST 1754.7, all clinical providers will participate in clinical supervision or consultation, depending upon their level of competence and designated privileges. Providers working toward licensure should inquire about all requirements and restrictions regarding state required supervision from the licensing board where they are applying for licensure/certification. States vary considerably with regard to specific requirements. While the FSC should assist in development of a professional development plan for non-privileged providers and should facilitate progress toward privileged, independent practice, achievement of the appropriate expertise and education requirements to be clinically privileged to practice independently is the responsibility of the individual. If clinical supervision for non-privileged clinical providers is not

available within the FSC, provisions for clinical supervision can be arranged with the nearest MTF or a local mental health service/independent clinical practitioner.

5.4.1.4.1 INDIVIDUAL SUPERVISION

- **Sessions**
  Individual supervision for non-privileged providers is strongly advised. There should also be mechanisms in place for privileged practitioners to seek individual consultation with the Chief of Clinical Services or other privileged practitioners whenever needed. The level and frequency of supervision should be agreed upon depending on the competency and skill of the provider, credential status, and state licensing requirements.

- **Audiotapes**
  One cost-effective method to access the "live material" which is essential to providing comprehensive clinical supervision is through the use of audiotapes. Before the onset of taping, FSC clinical providers are reminded that they should obtain consent from the client (Refer to Attachment 16, Administrative Case Record Management, for a sample release form). Non-privileged clinical providers should tape record at least one clinical counseling session per month to be used in conjunction with their individual clinical supervision. These tapes will be reviewed in supervision (Refer to Attachment 34 for Clinical Counseling Quality Control Audiotape Review Form).

- **Observation/Videotapes**
  It is strongly recommended non-privileged clinical providers be observed by the Clinical Supervisor while conducting a clinical counseling session either by way of a one-way mirror or by videotaping the session. How often a clinical provider is observed depends on the availability of the appropriate equipment and office space at each FSC.

It is strongly recommended that Clinical Supervisors make every effort to use one of these methods of supervision at least once each quarter. They provide an opportunity for the Clinical Supervisors to assess their non-privileged clinical providers' clinical skills and monitor their progress, and they provide non-privileged clinical providers with valuable feedback which contributes to improvement of clinical skills.

5.4.1.4.2 GROUP SUPERVISION

Group supervision can involve case review, a presentation by a community provider or a clinical specialist, an audiotape or videotape of a clinical counseling session which is reviewed, a viewing of an educational film, or a panel presentation on a specific clinical topic. The learning experiences are designed primarily for the group context. Some states may specify the percentage of group vs. individual supervision required for licensure.

Group supervision has many advantages. It economizes the Clinical Supervisor's time, provides an opportunity for the Clinical Supervisor to share his or her experiences with problems encountered in the agency and receive feedback on possible solutions, and provides exposure to a greater variety of clinical cases for the non-privileged clinical provider than is available in any one caseload. Consequently, the sources for learning are richer and more varied than in the individual conference.

Individual and group supervision each provide unique learning opportunities for the clinical provider. Every effort should be made to make both individual and group supervision available to FSC clinical providers.

5.4.1.4.3 PEER CONSULTATION FOR CLINICAL SUPERVISORS

Supervisors need the opportunity to obtain feedback on clinical and supervisory issues. There is usually one Chief of Clinical Services at the FSC, although other clinical practitioners may be qualified at the Tier III level and be privileged to provide clinical supervision. Although clinical supervisors are supervised by either a Chief of Clinical Services or FSC Director, their supervisors do not necessarily have a back-ground in clinical counseling. Therefore, seeking out supervision for the Clinical Supervisor (or for the FSC Director who has clinical responsibilities) is often the responsibility of the individual who holds that position.

The responsibility may require the individual seek consultation from a professional outside of the agency, either in the military or civilian community. Consultation is also recommended for isolated or remote sites with a limited clinical counseling staff. Another option is to form a peer supervision group which could involve meeting monthly with other clinical supervisors from neighboring FSCs or networking with practitioners from community agencies and meeting on a regularly scheduled basis.

5.4.2 TRAINING AND PROFESSIONAL DEVELOPMENT

5.4.2.1 JUSTIFICATION

Training is a vital component in a QA plan to ensure clinical staff continue to grow and develop professionally. Staff training and professional development are a critical component to a successful and highly functioning clinical counseling services unit. Education and training can encourage and energize clinical providers and alleviate burnout.

Continuing education and professional development is a cornerstone of most clinical professional organizations, such as the NASW and AAMFT. Within the FSC system, the importance of staff training is clearly stated in NMPC 1754 Ser156/A704 11 May 89. Further, the Accreditation Quality Standards require specific training on in-house procedures as well as recommendations for clinical training for clinical providers (Refer to Section 5.4.2.1.6).

5.4.2.1.1 CONTENT

It is essential that FSC clinical providers receive training in two major areas:

- **Military-related issues**
  Guidance Memorandum NMPC 1754 Ser 156/A704 11 May 1989, Family Service Center Staff Training, Confidentiality and Referral Procedures states:

  "The FSC Director or Acting Director is responsible for ensuring all newly reporting FSC staff receive appropriate training regarding Navy and FSC regulations and procedures. This training should include, but is not limited to: the Navy mission and the specific base/tenant commands' mission; chain of command, both base-level and internal to the FSC; Navy rights and responsibilities; Navy correspondence; basic military protocol with seniors and subordinates; "by direction" authority; Standards of Conduct; and applicable Navy customs and traditions. This "Navy-ization" and orientation of staff is important to the effective performance of all staff members and such training shall be conducted for new personnel as soon as feasible. A periodic review of those matters during in-service trainings is required and should be conducted at least annually.

  Other resources such as base orientations, Navy Information School, and Navy Rights and Responsibilities classes can be used to facilitate the training process. Further, it is recommended that each FSC should develop local standard operating

procedures (SOPs) for the various FSC functions. For example, SOPs about the release of information, handling potential suicides, Information and Referral, and proper referral procedures can complement and expand on information provided in orientation and staff trainings and serve as a daily reference."

- **Clinical issues**
  It is imperative that clinical providers keep abreast of clinical practice skills, interventions, and research which deal with the types of problems being treated within the client population served. It is necessary for FSC clinical providers to develop sound practice skills in the areas of information and referral, crisis intervention, catastrophic response, and brief therapy. They should also be able to work with individuals, couples, families and groups addressing such issues as work-related stress, marital discord, parenting, adult survivors, financial difficulties, frequent relocation, family separations, geographical isolation, etc.

5.4.2.1.2 IN-SERVICE TRAINING

In-service training is an educational opportunity for staff members which is provided by the agency at no cost to the employee and generally takes place at the agency or in the local community. Sources which can be tapped to provide in-service training include:

- **FSC Staff**
  Clinical providers who have attended conferences or seminars can bring the information back to the FSC and present a mini-training session for those clinical providers and other interested FSC staff who did not attend. Other FSC staff members can educate clinical providers about some of the other resources/programs available within the agency.

- **Staff from Other FSCs**
  In some geographical areas there are several FSCs located within close proximity of one another. These FSCs rotate hosting a training at their facility, inviting personnel from each of the neighboring FSCs. Periodically, the training is provided by FSC staff members who share new information and approaches to common issues and problems faced by all of the FSCs.

- **Military Resource Providers**
  Invite representatives from the Red Cross, Navy-Marine Corps Relief Society, ARD, Chaplain's Office, Psychiatry Department, etc. to describe the services they provide and to answer questions.

- **Civilian Community Agencies**
  Invite staff from human service agencies in the local community to describe the resources they have available for military personnel and their families and to answer questions which also creates an opportunity for clinical providers to network with other professionals.

- **Private Practitioners**
  Invite private practitioners/TRICARE providers who have a clinical area of expertise, and request they make a presentation on the subject. However, they cannot solicit referrals and must **NOT** provide information regarding acceptance of TRICARE clients.

5.4.2.1.3 EXTERNAL TRAINING

External training opportunities include conferences sponsored by nationally recognized professional organizations (e.g., National Association of Social Workers); Navy-wide training, FSC conferences, and FAP training, and other workshops and seminars which are sponsored locally by community agencies and professional organizations. It is the responsibility of the Clinical Supervisor and the clinical providers to assess the most appropriate training opportunities based on the subject matter, need, cost, location, date, staff coverage, etc. Training opportunities should be distributed among the staff in the most equitable way possible to ensure that all clinical staff members have the opportunity to upgrade their clinical skills.

5.4.2.1.4 CROSS-TRAINING

FSC clinical providers are required to perform a wide variety of job tasks which can include any combination of the following: individual, couples, family and group clinical counseling; parenting groups; educational presentations on FSC and its services; General Military Training for commands on any number of topics, such as anger management, stress management, etc. Therefore, it is necessary for clinical providers

to be cross-trained in a variety of areas. Cross-training gives the clinical provider an opportunity to practice a wide variety of skills in different settings and also creates a diversified pool of qualified staff.

5.4.2.1.5 RECOMMENDED SCHEDULE OF TRAINING

Training opportunities are often dictated by the availability of funds, staff time, and a space to accommodate the training. Providing educational opportunities requires planning and creativity to overcome these obstacles. With regard to professional continuing education, the FSC will ensure providers have an opportunity to obtain 16 hours of continuing education annually.

5.4.2.1.6 CLINICAL PROVIDERS TRAINING REQUIREMENTS

Clinical providers are required to maintain and update their clinical skills and to receive training in current practices and standards within the FSC in order to best serve the client population. Listed below are the minimum training requirements and their frequency.

Required Training	Frequency
New Staff Orientation and Training (for all new clinical staff)	
Orientation to FSC and U.S. Navy	
Accreditation Quality Standards Overview	
Ombudsman Program	
EFM Program	
QOLMIS Training	
Clinical counseling Desk Guide	Upon Hire
Cultural Diversity in the Workplace	Annual
EEO/Sexual Harassment	Annual
Confidentiality Training	Annual
Information and Referral Training	Annual
Standards of Conduct	Annual
Continuous Improvement Training	Annual
SOP Development Training	Annual
Command Representative Training	Annual
Return and Reunion Training (if applicable)	Annual
Crisis Response Training	Annual
Crisis Intervention Training	Annual
Clinical Training (recommended)	16 hours annually
DSM-IV Training	Once per employee

5.4.3 EVALUATION OF CLINICAL SERVICES

Evaluation within the FSC clinical counseling unit should focus on two areas:

- **Service Providers**
  How effective are the individuals (clinical providers) who provide the services?
- **Services**
  How effective are the actual services?

5.4.3.1 CLINICAL PROVIDERS

The performance level of a clinical provider is evaluated through the methods which have been described in Section 5.4.1 Case Supervision: individual and group supervision; audiotapes and videotapes of clinical counseling sessions; and case review by the supervisor, peers, and outside consultation when possible. The clinical provider can also utilize the clinical counseling Self-Assessment Form (Refer to Attachment 35).

5.4.3.2 CLINICAL COUNSELING SERVICES

Clinical counseling services can be evaluated using the following tools:

- **Client Feedback**
  Distribute questionnaire after last clinical counseling session or mail to home. Call a random sample (5%) of individuals who were intake callers (Refer to Attachment 33 for Client Evaluation of Services form).
- **Command Feedback**
  Distribute questionnaire to commands who referred active duty members for clinical counseling.
- **Needs Assessment**
  Include a segment on clinical counseling services in the Needs Assessment conducted by the FSC or the Installation.

PART SIX:
Family Advocacy Program

This chapter is intended to provide a general overview of the Family Advocacy Program (FAP), particularly as it pertains to FSC clinical counseling staff. For specific instructions, guidance and directions about the FAP program, refer to the *Family Advocacy Program Desk Guide* and pertinent Navy policy, both of which provide more detailed policy and guidance for FAP staff.

6.1 OVERVIEW

The Navy's position on family violence is clearly stated in OPNAVINST 1752.2A, Family Advocacy Program:

Spouse and child abuse has a negative effect upon military readiness, effectiveness, and good order and discipline. Accordingly, response to spouse and child abuse is a leadership issue. Commanding officers will undertake a continuous effort to reduce and eliminate child and spouse abuse at every level of the command. When suspected child or spouse abuse by a service member comes to the attention of the member's commanding officer, he or she will take prompt action to include holding the member accountable for his or her behavior. Additionally, commanding officers shall undertake measures to prevent further violence to the victim(s), and promote victim safety.

The five primary goals of the FAP are:

- Prevention
- Victim safety and protection
- Offender accountability
- Rehabilitative education and clinical counseling
- Community accountability/responsibility for a consistent and appropriate response

During the early 1970s, increased awareness of child maltreatment prompted the Navy Surgeon General to advocate a program dealing with both the medical and social aspects of the problem. In 1976, the Child Advocacy Program was established within the Navy Medical Department for dependent children who were abused or neglected. In 1979 this program was expanded to include spouse abuse, sexual assault, and rape. It was designated as the Family Advocacy Program (FAP). With the dissemination of OPNAVINST 1752.2A in 1996, FAP moved from a medically managed program as part of BUMED to a line managed, multidisciplinary program. The continued role of medical personnel in support of the Family Advocacy Program is delineated in BUMEDINST 6320.70.

6.2 DEFINITIONS/ACRONYMS

The following definitions are intended to provide clarification of key terms and functions within the Family Advocacy Program. Whenever possible, comments will include how the term/function pertains to FSC clinical counseling staff. These definitions are, for the most part, adapted from OPNAVINST 1752.2A.

CASE: A case refers to a single victim who may be involved in one or multiple abuse incidents. Individual cases involving members of the same family are linked via cross-referencing.

CASE MANAGER: A person who assesses the needs of clients and families, arranges, coordinates, monitors, evaluates and advocates for multiple services to meet the needs of families in which there are allegations of spouse and/or child abuse. Within FAP, this includes serving as the point of contact for the active duty member's command, providing ongoing assessment, identifying and assisting clients in meeting specific needs, presenting case information to the CRC, monitoring treatment compliance and progress, providing treatment within varied modalities, and documenting all actions/contacts.

CASE REVIEW COMMITTEE: A multi-disciplinary team responsible for reviewing case assessment, determining the status of the case, identifying the offender whenever possible, and making intervention/administrative recommendations. The CRC consists of five required core members (a Line Officer, Judge Advocate General, Credentialed Mental Health Provider, FAR and Medical Officer) and other members.

FSC clinical counseling staff may serve on the CRC as the core Mental Health Provider or other member. Appointments to the CRC are made in writing and annual training requirements apply. Consult the FAR regarding your role and responsibilities if you are appointed to the CRC.

CASE STATUS: The status of an incident of alleged abuse, as determined by the CRC. Possible determinations include:

- **Substantiated:** The preponderance of available information indicates that abuse has occurred. In other words, the information that supports the occurrence of abuse is of greater weight, or more convincing, than the information that indicates that abuse and/or neglect did not occur.
- **Unsubstantiated, Did Not Occur:** The preponderance of available information does not support that abuse occurred. The family receives no further FAP services.
- **Unsubstantiated, Unresolved:** A preponderance of information is lacking to either support or rule out an allegation of abuse. Family advocacy involvement ceases, although a referral for prevention and/or family support services may occur. Any recommendations are strictly voluntary in nature.
- **Pending:** Case status determination is postponed pending further assessment/information.

CENTRAL REGISTRY: A central management information system maintained by Navy Personnel Command (PERS-661) for identifying and recording information on child and spouse abuse incidents. Information is forwarded to the Navy Central Registry regarding data elements specified by the Department of Defense (DOD). FAP is converting this system from mechanical entry of report forms to automated report submission, via the FAP Automated Case Management System. The Central Registry is maintained largely to assist the FAP program in tracking and managing cases worldwide and in facilitating background checks of those working with children.

CHILD: Refers to all persons under the age of 18 who have not been emancipated, regardless of military affiliation. Persons 18 years or older who are adjudged legally incompetent may be considered children for the purposes of FAP involvement.

CHILD ABUSE/NEGLECT: The physical injury, sexual abuse, emotional abuse,

deprivation of necessities, or other abuse of a child by a parent, guardian, employee of a residential facility, or any person providing out-of-home care, who is responsible for the child's welfare, under circumstances that indicate the child's welfare is harmed or threatened. The term encompasses both acts and omissions on the part of such a responsible person. This term includes offenders whose relationship is outside the family and includes, but is not limited to, individuals known to the child and living or visiting in the same residence who are unrelated to the victim by blood or marriage, and individuals unknown to the victim. For definitions of specific types of abuse, refer to OPNAVINST 1752.2A.

FAMILY ADVOCACY COMMITTEE (FAC): The policy-making, coordinating, recommending, and overseeing body for the installation FAP. This committee generally includes representatives from victim/witness services, family support programs, medical, law enforcement, legal, chaplains, youth and child services, shelters, installation and tenant commands. FSC clinical counseling staff may serve on the FAC.

FAMILY ADVOCACY OFFICER (FAO): The FAO is a designated official who is responsible for administrative management and implementation of the installation FAP. The installation FAO shall facilitate the development, oversight, coordination, administration, and evaluation of the FAP in accordance with installation and service directives. The FAO shall be responsible for maintaining clear lines of authority and accountability in the FAP to ensure coordination of the FAP functions and the integration of services, including drafting installation instructions, coordinating Memoranda Of Understanding (MOUS) with civilian agencies, and ensuring there are written case protocols. A FAO does not decide clinical issues but might, for example, ensure that CRC's meet regularly. He or she does not become involved in case intervention plans. The FSC Director may be appointed the FAO.

FAMILY ADVOCACY PROGRAM REGIONAL COORDINATOR: The FAP Regional Coordinator provides technical and clinical oversight to FAP programs. Responsibilities include:

- Providing consultation and assistance to local FAOs and FARs
- Monitoring expenditure of FAP funds for the region
- Ensuring effective coordination, cooperation, and collaboration between and among agencies and commands.

FAMILY ADVOCACY REPRESENTATIVE (FAR): A credentialed and privileged independent practitioner who is responsible for implementing and managing the intervention/rehabilitation aspects of the installation FAP.

MAJOR PHYSICAL INJURY: This includes brain damage, skull fracture, subdural hemorrhage or hematoma, bone fracture, dislocations, sprain, internal injury, poisoning, burn, scald, severe cut, laceration, bruise, welt, or any combination thereof, which constitutes a substantial risk to the life or well-being of the victim.

OFFENDER: See also Primary Aggressor. Any person who allegedly caused the abuse of a child or spouse, or whose act, or failure to act, substantially impaired the health or well being of the abuse victim.

PRIMARY AGGRESSOR: The person who maintains power and control in an abusive incident regardless of which party started the physical or verbal action, the party who continued the dispute, or the party who "provoked" the event. This eliminates the terms "co-battering", "mutual battering", or "mutual spouse abuse".

REGIONAL CHILD SEXUAL ABUSE RESPONSE TEAM: Multi-disciplinary team from a designated installation or area, which has received specialized training concerning the intervention process for complex and/or multiple victim cases of child sexual abuse. Teams normally consist of a judge advocate, Naval Criminal Investigative Service (NCIS) special agent, FAR, pediatrician and social service professional from the Navy Family Service Center (FSC). These teams are available for consultation in their regional areas.

REHABILITATION/CLINICAL COUNSELING FAILURE: An offender is deemed to be a rehabilitation/clinical counseling failure when he or she has been found guilty at a criminal trial, or found to have committed the offenses at nonjudicial punishment, or have admitted to the offense, or the allegations are substantiated against him or her and thereafter:

- does not cease his or her abusive behavior before, during, or after participation in clinical counseling services; or
- refuses to cooperate or complete clinical counseling programs; or
- fails to meet the conditions of court orders or probation; or
- fails to make adequate progress in rehabilitation, education, and clinical counseling as determined by an expert in the rehabilitation, education, and clinical counseling

of child or spouse abuse offenders.

FSC clinical counseling staff who are providing counseling to FAP clients should provide regular progress reports to the CRC regarding treatment progress and whether an offender is deemed a rehabilitation/counseling failure. This is particularly important in the case of active duty clients, who can be referred for administrative separation processing as a result of FAP rehabilitation failure.

SPOUSE: A partner in a lawful marriage where one or both of the partners are employed by, or are military members in the Department of the Navy (DoN) and are eligible for medical treatment from the DoN. A married person under 18 years of age shall be included in this category.

SPOUSE ABUSE: Spouse abuse includes, but is not limited to, assault, battery, threat to injure or kill, or any another act of force, violence, or emotional abuse, or undue physical or - psychological "trauma, or fear of physical injury. This includes physical injury, sexual assault, and intentional destruction of property, psychological abuse and stalking. Abuse, as defined here, often occurs between those who are involved, but not married. For the Navy's purposes, this includes couples who are living together or who show a relationship pattern (e.g., live together on and off, share a child together, previously married). Current Navy policy states that abuse between unmarried intimate partners will be treated the same as spouse abuse cases in terms of notifications and case processing. Victims who are not eligible for military medical care are seen by FAP for information and safety planning purposes, and referred to the appropriate civilian agency for assistance. They can be referred to Victim Service Specialists (VSS) for assistance and referral, when available at the installation.

VICTIM: An individual who is the subject of abuse, or whose welfare is harmed or threatened by acts of omission or commission by another individual or individuals.

VICTIM SERVICES SPECIALIST (VSS): A supportive resource and advocate for the expressed interests of the victim. This person need not be a legal or mental health professional but must be able to assist the victim in contacting, accessing or using established military and civilian victim assistance services to support the victim's needs and to keep the victim informed of official DON action. The VSS may serve as a consultant on the CRC, presenting factual information regarding the case being presented and providing general information about the needs and interests of victims. They are not serving as a particular victim's advocate. FAP-sponsored VSS are not

available on all installations, although most larger communities have victim advocates to assist in domestic violence cases, often in association with the local shelter. Child advocates are also available in larger communities, usually through Child Advocacy Centers. Networking and developing Memorandum of Understanding (MOU) with shelters and family violence victim advocacy agencies in the community is very important.

6.3 ROLE OF FSC CLINICAL COUNSELING STAFF IN FAMILY ADVOCACY

The Family Advocacy Program is located within FSC in most sites, within the Military Treatment Facility (MTF) in limited sites and are free-standing at fleet concentrated areas (currently, San Diego, Norfolk, Pearl Harbor and Bremerton). Regardless of the location of FAP staff, FSC family support programs, the MTF, other installation programs, tenant commands and the installation command must work effectively together with FAP to provide family advocacy functions. The FAC is a key way in which the military community coordinates efforts, both within the installation and with the surrounding civilian community.

FSC clinical counseling staff and FAP staff, whether they are across the hall or across the installation, work together to provide a full spectrum of prevention, assessment and intervention services to individuals and families who are at risk for, or have a history of, family violence. The model of how these services are delivered will differ from installation to installation based on the mission, personnel, organizational structure and geographic location. Each FSC has responsibility for providing aspects of the following elements in support of the FAP:

6.3.1 PREVENTION AND EDUCATION

Current Navy policy and guidance regarding family violence prevention and education activities are promulgated in the following:

- DODINST 6400.1-M, FAMILY ADVOCACY PROGRAM STANDARDS AND SELF-ASSESSMENT TOOL
- SECNAVINST 1754.1A, DEPARTMENT OF NAVY (DON) FAMILY SERVICE CENTER PROGRAM
- SECNAVINST 1752.3A, FAMILY ADVOCACY PROGRAM

- SECNAVINST 1752.2A, FAMILY ADVOCACY PROGRAM
- BUPERS ltr 1752 Ser 661D/264 of 21 Nov 94, PREVENTION OF CHILD AND SPOUSE ABUSE

DOD FAP standards delineate the differences between educationally-based and clinically-based programs.

Educationally-based services, also called Level One services, have been defined as programs whose intent is to convey information and awareness without becoming involved in (or making clinical interpretations regarding) the individual or group dynamics. These programs may include practice to increase self-awareness, but are not aimed at developing psychological insight. In other words, they typically provide generally available information to participants. These programs have been provided by the FAP, other military programs, including the FSC, and community agencies.

Traditionally, educationally-based programs have been provided by Family Advocacy Specialists in FSCs, although realignment of FAP from the medical command to line command has resulted in redefinition of these positions. Clinical (professional mental health) credentials are not required for an individual to provide Level One services.

Prevention programs can be presented to different audiences, such as the general public (often called primary prevention), those identified "at risk" for the problem targeted for prevention (secondary prevention), or those identified as already exhibiting the problem (tertiary prevention or intervention). As a general rule, when programs move from primary to tertiary prevention, they should probably become more focused, specialized and clinical in orientation.

While life skills educational programs generally have the valuable goals of enhancing self-esteem, strengthening interpersonal competencies and fostering personal wellness, they are not necessarily family violence prevention programs. To be effective, prevention programs must be clearly focused on identified factors which contribute to the problem we wish to eliminate or reduce, particularly if the target audience has been identified "at risk" for that problem.

Examples of family violence prevention programs are listed in Enclosure (2) of OPNAVINST 1752.2A. Thus, it is important to remain current on the latest research regarding family violence prevention strategies and the effectiveness of those strate-

gies. For example, there is no research to suggest that Level One (i.e., educational) stress management or anger management programs are effective prevention/intervention strategies for spouse abusers.

However, there is research to suggest that home visitation and other early parental enrichment programs are effective in preventing child abuse. The Navy's New Parent Support Program (NPS) is a FAP program that provides several levels of service for new parents, with the most intense level of service offered to those new parents screened to be at risk. For installations without a New Parent Support, it is strongly recommended that a NPS point of contact within the FSC be established to provide information and referral to new parents and to develop partnerships with community agencies that provide such services.

6.3.2 TRAINING

The FAP has a number of training requirements to varied audiences including CRC members, law enforcement, FAP command points of contact, and Commanding Officers. Refer to local instructions and protocols to determine the extent to which FSC clinical counseling staff are responsible for training regarding family violence, in general, and the FAP, in particular.

6.3.3 IDENTIFICATION AND REFERRAL

Navy policy specifically mandates that all child abuse and some spouse abuse be reported to the FAR. When active duty or family members present information at initial screening that is suggestive of suspected child or spouse abuse, referrals should be made directly to FAP. Scheduling of an intake assessment with FSC clinical counseling staff needlessly delays referral to FAP, which may place family members in danger.

When either child or spouse abuse is disclosed in the context of ongoing clinical counseling, FSC clinical counseling staff should have no proprietary interest in continuing counseling. Failing to screen for such problems during intake assessment or, once identified, focusing counseling on other identified problems is NOT acceptable. The following procedures should be strictly followed:

6.3.3.1 CHILD ABUSE/NEGLECT

Current Navy policy (OPNAVINST 1754.2A) states that any known or suspected incident of child abuse occurring on a military installation or involving persons eligible for FAP services must be reported to the local Family Advocacy Representative (FAR). Child abuse includes emotional, physical and sexual abuse, as well as neglect.

When an incident of suspected child abuse involving a military medical beneficiary (i.e., active duty member, family member of an active duty member, or Department of Defense (DOD) employee overseas) is disclosed during clinical counseling, the clinical provider is required to report this to the FAR. Such disclosures are authorized by the Privacy Act. The procedures for making a report to FAP are detailed below.

Current Navy policy requires the FAR to notify:

- the member's command, depending upon the results of an initial assessment,
- the state or civilian agency having child protective service function (hereafter referred to as Child Protective Services (CPS), consistent with applicable laws and Memorandum of Understanding,
- local authorities in overseas installations, in accordance with applicable treaties and Status of Forces Agreements (SOFA),
- the appropriate law enforcement/security department personnel if there is major physical injury or indication of an intent to inflict major physical injury, and
- Naval Criminal Investigative Service (NCIS) in the case of child sexual abuse or other felony level family violence, and Navy Personnel Command (PERS-661) in cases of suspected child sexual abuse. More immediate reporting requirements apply in instances of alleged child sexual abuse in DOD sanctioned out-of-home child care settings.

In the absence of a FAR, incidents of known or suspected child abuse are reported directly to CPS and to law enforcement/security if there is imminent danger to the child.

In cases where suspected child abuse is uncovered during counseling with clients who are not eligible for military medical care (e.g., retirees or their family members), the FAR may be consulted to provide guidance and the clinical provider must report to CPS. Reports to CPS should be made within 24 hours.

Specific procedures and requirements for reporting vary from one CPS agency to another. **It is recommended that the FSC incorporate a copy of all local and state laws and any applicable MOU regarding suspected child abuse/neglect into the written family violence protocol.**

When reporting to CPS, be prepared to provide the following information:

- name, social security number, and address of the child and guardian/parent,
- child's age and sex,
- description of alleged abuse/neglect,
- name of others, particularly children, living in the home.

NOTE: Regardless of whether a case of suspected child abuse is referred to FAP or the civilian CPS agency for assessment and management, the FSC clinical provider remains responsible for the case and for safety concerns until FAP or CPS assumes responsibility. In other words, an FSC clinical provider should **always** conduct a safety assessment and safety planning whenever suspected child abuse is disclosed within the context of counseling. Recommended procedures for completing safety assessment and safety planning are outlined below.

6.3.3.2 SPOUSE ABUSE

Spouse abuse is the most frequently reported type of family violence in the Navy and frequently co-exists with child abuse. Whenever a FSC clinical provider becomes aware of spouse abuse, for example, they should always inquire about possible child abuse and vice versa. However, when inquiring about possible family violence, **NEVER** question family members together because it may inhibit their ability to provide information freely or expose them to greater danger. Violence between unmarried intimate partners is also assessed and managed by the FAR, as noted above.

Civilian jurisdictions vary with regard to the reporting of intimate partner abuse. **Therefore, it is recommended that the FSC insert a copy of all local and state laws that apply to reporting of intimate partner abuse in their written family violence protocol.**

Current Navy policy (OPNAVINST 1754.2A) allows more latitude (than in the case of child abuse) when reporting spouse abuse to FAP and a member's command. Possible scenarios are outlined below.

If a **VICTIM** of alleged spouse abuse comes voluntarily to the FSC seeking counseling, the clinical provider is NOT required to report the incident if:

- there are no current injuries, and
- the victim is responsive and capable of responding to any renewed threat, and
- previous abuse did not result in "major physical injury," as defined above, and
- safety assessment does not indicate immediate danger, and
- safety planning has been done, and
- the victim does not want it reported.

If **ALL** of the above are true, the FAR and the clinical supervisor (in the case of non-privileged clinical providers) should be consulted before it is decided that suspected spouse abuse will not be reported. (When consulting with the FAR, the identity of the couple should be disclosed to the FAR, after it is made clear that you are requesting consultation and not reporting, in case the FAR is aware of previous instances of abuse between these parties that have not been disclosed to you.)

Whenever a decision is made to not report spouse abuse, the case notes should clearly reflect the results of risk/safety assessment and safety planning, the results of consultation, and the rationale for not reporting to FAP.

If at any time while working with the victim, the clinical provider comes to believe that the victim is in imminent danger, the provider must report the situation to the FAR and the service member's command and take necessary steps to promote the victim's safety. Possible safety responses are detailed below.
If a victim of spouse abuse comes voluntarily to the FSC and there **ARE** current injuries:

- refer the client to the appropriate MTF for treatment, and
- notify the FAR and law enforcement personnel.

If an **OFFENDER** of spouse abuse present voluntarily to the FSC seeking counseling:

- gather information to complete the incident report (from the Navy Risk Assessment Model) and to assess for the immediate safety of the victim, and
- make a report to FAP.

Current Navy policy provides no specific guidance on reporting requirements when a couple comes voluntarily to an FSC for assistance with spouse abuse. Best practice suggests that the provider should:

- see the individuals separately to thoroughly assess the history of violence,
- complete safety assessment and safety planning with the victim,
- assess whether the issues above pertaining to not reporting when victims present voluntarily are applicable, and
- consult with the FAR and the clinical supervisor (in the case of non-privileged providers) or Chief of Clinical Services on whether or not a report should be made to FAP.

The FSC clinical provider who is conducting couples counseling when a history of family violence is revealed should very carefully document the assessment and safety planning efforts, the results of consultations, and the decision process regarding reporting to FAP.

Couples counseling within the context of spouse abuse can be helpful for a very small percentage of couples and in very limited situations, but should be used very judiciously and only after thorough, careful assessment of the individuals and the violence history. Periodic assessment of the ongoing safety (through individual contacts with the victims) should also be done. In most cases, this should probably occur after thorough assessment, review by the Case Review Committee, and CRC recommendation for couples counseling, with continued monitoring by the FAP/CRC during the couples counseling.

NOTE: As with child abuse, the FSC clinical provider remains responsible for the case and for safety concerns until FAP or civilian agencies assume responsibility. Communication and coordination of efforts with FAP staff are critical, regardless of where FAP staff are located. FSC clinical counseling staff should always follow-up with the FAR to insure that a referred client has been seen or scheduled for assessment.

6.3.3.3 PROCEDURES FOR REPORTING TO FAP

When making a report to FAP, FSC clinical counseling staff should complete the

- incident report,
- safety assessment, and
- safety response contained in the Navy Risk Assessment Model (NRAM).

Module II of the Navy Risk Assessment Handbooks provides procedural information for completing these forms and tasks. Inservice training with the FAR and FSC clinical counseling staff should also be scheduled. In sites where FAP is located within the FSC, arrangements can be made for FSC clinical staff to complete these forms in the FAP automated case management system. In FSCs where FAP is housed in another location from the FSC (mainly in FAP Centers), paper forms will need to be completed and forwarded to the FAR, unless an automated system of referral is developed at some future date.

- The incident report form should be completed, using the Navy Risk Assessment Model format (Refer to Attachment 36). When completing this report, provide specific and detailed description of the incident, including the injuries (both observed and reported), what led up to the abusive incident, and any victim and/or witness statements. This information should be provided with regard to all types of abuse that apply.

  NOTE: The eligibility decision and case status decision noted at the end of this form are completed by FAP staff, upon receipt of the referral. FSC clinical counseling staff are mandated to report in cases of suspected child abuse, even if the incident is later deemed ineligible for FAP services.

- Safety Assessment, as structured in the NRAM, is a yes/no checklist (Refer to Attachment 37). This form should be used when documenting safety assessment for the purposes of managing safety concerns prior to making a report to FAP. The form is designed to assist in the initial phases of information gathering; the provider should utilize all available information in completing the checklist.

  The safety assessment checklist is also useful as a screening device, when collecting historical information about the abuse, for the purposes of assessing future risk and decision-making regarding reporting to FAP of some spouse abuse cases.

The following information is gathered:

Dangerous Acts: liability or exposure to serious harm or injury, risk or peril; behavior of the alleged offender which results, or could result in, major physical injury to the victim. Use the definition of "major physical injury" above for clarification.

Imminent Harm: The alleged offender has access to the victim and there is imminent risk to the victim without immediate intervention.

Weapons: Weapons are defined as guns, knives, baseball bats, cars, or other implements which, when used as weapons, could cause lethal harm. In cases of domestic violence, the presence of a gun in the home is answered affirmatively. Actual use of a gun is not necessary to answer yes.

Threats of harm to self or others. This includes suicidal or homicidal ideation on the part of the victim, the alleged offender, or the non-offending caretaker of a child victim. Stalking behavior by the alleged offender is answered "yes."

Significant abuse-related harm: Includes: **(1)** Extensive physical injuries such as death, brain damage or skull fracture, subdural hemorrhage or hematoma, bone fracture, dislocation or sprain, internal injury, poisoning, burn or scald, severe cut or laceration, other physical injury that seriously impairs the health or physical well-being of the victim **(NOTE:** Seek emergency medical evaluation if this is endorsed.) **(2)** Serious emotional trauma that requires emergent psychiatric assessment.

Failure to meet basic needs: Includes lack of supervision of minors, and failure to provide family members food, shelter, and/or clothing such that **serious harm** may occur. Refer to Module III neglect-related items under the Dangerous Acts factor that are considered to be moderately high to high risk for as a means of assessing acts which have the potential to result in serious harm.

NOTE: As a general rule, if any of the first six items above are endorsed regarding a recent incident, imminent danger is suggested and immediate safety planning is required. Immediate referral to FAP is advised. If any of these items are true regarding historical abuse, higher risk is suggested and the case should definitely

be referred to FAP for further evaluation and monitoring. High risk items regarding the history of abuse should be documented and forwarded to the FAR at the time of report.

Victim Vulnerability: Refers to all victims in the situation. Children under five are considered more vulnerable, as is any victim who is physically, mentally, emotionally disabled or especially unable to project him or herself. In the case of domestic violence, pregnant victims or those who are attempting to leave the relationship are answered yes.

Alleged offender has pattern of abusive behavior: This refers to a pattern of abusive or assaultive behavior to persons inside and outside the family, as well as the alleged offender's lack of acknowledgment of the problem.

Prior FAP and/or CPS reports: Generally substantiated reports, although any admitted history is of note.

Use of drugs or alcohol: Includes use/abuse by any of the parties involved, particularly during violent episodes. Endorsement (both situationally and chronically) regarding any family members signals increased risk.

Fear of caretaker/spouse expressed: Note verbal and nonverbal expressions in children.

Non-protective/uncooperative non-offending parent: Self- explanatory.

Note any factors judged to be of importance with regard to immediate safety.

NOTE: As a general rule, if any of the last seven items are endorsed (in the absence of the first six), with regard to either recent or historical abuse, at least some risk is indicated, safety planning should be conducted and the case should referred to FAP. If none of these items are endorsed, refer to the procedures above regarding reporting requirements for spouse abuse.

- Safety planning is accomplished by completing the Safety Response (Refer to Attachment 38). It follows directly from the safety assessment and documents all actions taken, immediately or recommended in the future, to insure the safety of each victim. If alternative placement of the victim or alleged offender has occurred at the time of report to FAP, this should be documented. Immediate referral to the VSS, if available at the installation, or to a community victim advocate, for safety planning is generally recommended.

Refer to the *FAP Desk Guide* for detailed information about safety planning. As an overview, safety planning may include

For victims:

- The Safety Plan is to remain confidential.
- Protective orders and legal protection discussed and assistance provided with implementation of the plan.
- Danger signs reviewed (identify triggers).
- Transportation plans developed. An extra set of car keys should be hidden to be used only when activating the Safety Plan. The telephone numbers of friends/relatives who have agreed to provide transportation in emergencies need to be hidden and available when needed for safety purposes.
- Accessing safe and confidential shelter options.
- Emergency money. Extra money should be hidden for use when the Safety Plan is activated.
- Community and FSC/FAP support discussed.
- Need for flexibility during implementation of Safety Plan stressed.
- Rehearsal of Safety Plan.

For offender(s):

- Short-term, voluntary removal of the offender from housing (active duty offenders) to defuse the situation.
- Recommendation of military protective order to the member's commanding officer.
- Bar abusive family member (offenders) from the installation.

6.3.4 INTERVENTION

In the DoD FAP standards, Level Two services are defined as clinically-based programs that specifically address issues related to child and spouse abuse. SECNAVINST 1754.7 requires all persons who are providing such services in the FSC or FAP Center to be clinically credentialed and to have those credentials reviewed for the purposes of privileging.

In practice, FSC clinical counseling staff provide a variety of intervention services,

either individually or in groups, to FAP clients who have been referred for counseling by the CRC. Clinical providers for children, located at some installations, focus upon the needs of children, particularly those who have been exposed to violence between their adult caretakers.

6.3.4.1 THE NAVY RISK ASSESSMENT MODEL (NRAM) AS AN INTERVENTION TOOL

In 1997, the FAP promulgated the NRAM, in accordance with DoD quality assurance standards. The NRAM was designed to enhance the consistency and quality of decision-making within the FAP system and was intended to focus, reframe and replace traditional psychosocial assessment. The NRAM assists FAP and Case Review Committee (CRC) personnel in making decisions regarding case acceptance, immediacy of the response required, level of assessment required, treatment and intervention planning, case closure, overseas screening, flagging for assignment control and advising commands.

The model consists of a mission statement and three risk assessment tools: the incident report and eligibility screen, safety assessment/safety response, and the risk assessment matrix. The model is applied to both child and spouse abuse cases. There are three handbooks containing these documents, as well as a refined FAP case decision-making tree, definitions, risk matrix examples, and a literature review of the factors used in the model. Any of these materials are available for your review from your FAR or from PERS-661. Review of these materials does not constitute adequate training to effectively conduct Navy risk assessment, however.

The Risk Assessment Matrix, within the NRAM, consists of seven domains in the case of child abuse or five domains in the case of spouse abuse. Information is gathered on a number of factors within each of these domains. Selection of specific factors for inclusion within each domain in the matrix was based largely upon research available at the time of model development. Risk is rated from none to high for each of these factors **after** all available information is reviewed and gathered, such as: interview of all involved parties; interview of other family members in the home; review of all ancillary information and documentation, such as medical and service records, statements to police/NCIS; and interview of any witnesses. After the Risk Assessment Matrix is completed, FAP staff use the individual factor ratings to establish (a) a risk rating regarding the likelihood of future abuse and (b) the likely severity of future abuse, should abuse reoccur. These two ratings then determine the overall level of risk.

While FAP assesses and manages cases based on individual incidents of abuse, the NRAM provides comprehensive assessment and prediction about the degree of future risk to this victim or family, based upon examination of historical, as well as incident-related factors, using factors that have been shown in research to be associated with the abuse in question. Thus it was specifically designed to provide a structured and standardized approach to determining when a situation presents high risk for a victim, even if the incident itself was relatively minor in terms of actual or potential danger to the victim. There is not always direct correlation between the seriousness of a particular incident and the likelihood of serious future risk, and NRAM can capture these complexities.

This overview of NRAM is not intended to suggest that FSC clinical counseling staff should conduct formal risk assessment using the Navy model, without the benefit of specialized training. Nevertheless, NRAM provides a wealth of information to FSC clinical counseling staff who provide individual and group counseling (i.e., Level II services) to FAP clients. Interventions should be risk-focused, targeting specific identified risks and utilizing identified strengths.

Reports back to the CRC should also provide information about progress regarding targeted risks, as well as general compliance. Interventions should also keep in mind the overall level of risk in a family, with higher risk families/offenders requiring more intensive, structured approaches and closer monitoring. For example, if a FSC clinical counseling staff member is conducting a counseling group for substantiated spouse abusers, frequent regular contact with the victim is indicated for the high risk cases in order to provide ongoing assessment of victim safety and to provide validation of the offender's report.

Refer to the FAP Desk Guide for further information regarding best practice approaches when intervening in family violence cases.

6.3.4.2 FAMILIES IN NEED OF SERVICES (FINS)

In conjunction with NRAM, the Navy implemented procedures regarding Families in Need of Services (FINS) cases in 1997. This designation was designed to provide a differential response to family violence cases which did not appear to present significant risk. This differential response was intended to minimize fear of adverse career consequences as the major disincentive to reporting family violence, resulting in more effective early identification and intervention.

Decisions to designate a family as a FINS case are made after safety assessment and/or risk assessment **by FAP staff** determines that the overall level of risk is moderately low or lower and CRC reviews the case for quality assurance purposes and concurs with the FINS designation. The CRC usually makes recommendations about voluntary, beneficial services for the family. FINS cases are not opened as FAP cases; they do not require continued monitoring by FAP, and all recommendations to the family are considered voluntary. Additionally, the command does not have to be notified of the incident or respond with administrative or disciplinary consequences.

FINS case records are considered FSC clinical counseling records and governed by the Federal Systems Notice pertaining to those records. For example, paper records are destroyed two years after the date of last contact.

Services offered by the FSC are tailor-made for FINS cases. Life skills education and other early interventions, family violence prevention programs, referral to non-clinical FSC support programs (e.g., SEAP), and brief, problem-focused counseling for families/individuals in which more clinically oriented approaches are indicated, are all appropriate for assisting FINS families.

Coordination with FAP staff is important when a FINS designation has been made. Timely contact with these families by FSC staff (e.g., the FSC Chief of Clinical Services or other FSC clinical providers) should be made after the CRC review and notification to provide information about available programs and to invite participation, or to provide assistance regarding referrals if the family requests services that are not available or express a preference for being seen outside the military system. **However, it should always be made clear to these families that their participation is strictly voluntary.**

The FINS designation provides an important opportunity to intervene early with families and to intervene when they may feel more comfortable seeking assistance in the future.

In general, FSC clinical counseling staff play a critical role in prevention, identification, referral and intervention with family violence cases. Communication and coordination of efforts with FAP staff is necessary for effective case management. FSC clinical counseling staff play a very important role in the ultimate success of the Family Advocacy Program.

PART SEVEN:
Crisis Intervention

7.1 CRISIS INTERVENTION PROTOCOL

7.1.1 DEFINITION OF CRISIS

The terms *emergency* and *crisis* are often used interchangeably, but they describe two different types of situations which often require different interventions. **An emergency** is a life-threatening event or a potentially harmful situation (e.g., an individual who attempts suicide). **Crisis** is a more inclusive term which accounts for situations which are urgent but of a nonemergency type and which are a threat to loss of control or stability. Crisis is any situation which involves active duty members, family members, or eligible civilian personnel and is perceived by the individual, the command, another agency (military/civilian), or the FSC staff as an urgent need which requires immediate assessment. Although FSC clinical providers may be required to handle some emergency situations, more of their efforts are directed toward assisting clients who are in crisis.

7.1.2 PURPOSE OF A CRISIS INTERVENTION PROTOCOL

The primary purpose of the FSC is not to be a crisis intervention center but rather to focus on prevention and short-term treatment. However, individuals in crisis situations will present themselves at the FSC. The purpose of a crisis protocol is to:

- Educate personnel at installations about their role in crisis situations and what steps they should follow when providing assistance. It is vital that procedural guidelines be developed and put into writing **before** a crisis occurs to ensure it is handled appropriately and in a timely manner when a client in crisis does request assistance.
- Provide a standard operating procedure (SOP) within the FSC. The SOP can be used to train all staff members to familiarize them with the necessary steps to follow when individuals in crisis present themselves at the FSC. The SOP also aids in the therapeutic process by building staff confidence in their ability to handle crises.

- Develop MOUs (Memoranda of Understanding) with community resources (e.g., local police department, Department of Social Services, Child Protective Services Unit, local shelters, etc.). The purpose of this tool is to define the roles of community agencies in the crisis intervention process and to encourage them to work cooperatively with the military in assisting clients.

7.1.3 GUIDELINES FOR DEVELOPING A CRISIS INTERVENTION PROTOCOL

A crisis intervention protocol should be written in a clear and concise format which provides enough information on how to handle various scenarios. The protocol should be written as if the individual following it has no previous experience handling crisis situations. A staff member with no clinical background could be the first point of contact for a person who presents in the crisis at the FSC. Even clinically trained staff do not necessarily have experience handling all types of crisis situations. Therefore it is imperative a thorough explanation in a step-by-step format be provided to ensure optimum response to clients who seek assistance from the FSC. The information outlined in the following flow charts is designed to serve as a guide when developing a crisis intervention protocol for your local FSC.

7.1.3.1 DEVELOPING A CRISIS INTERVENTION PROTOCOL

1. ASSUMPTIONS

Basic information that should be included:

- Procedure needed for active duty members
- Procedure needed for family members
- Relevant local instructions
- Relevant Navy instructions
- Local resources used/phone numbers
- Reporting requirements
- Training
- Procedures during duty hours and during after duty hours
- Command expectation

2. ESSENTIAL ELEMENTS

- Handling initial contact
- Identifying individual in crisis (assessment)
- Developing safety action plan
- Providing necessary resources
- Liability issues
- Making appropriate referrals
- Reporting procedures
- Follow up
- Legal and medical aspects of crisis

3. ORGANIZATIONS/RESOURCES

A resource listing with identified points of contact (POCs) and phone numbers should be readily available. Examples include:

- Medical Treatment Facility
- Chaplains
- Base Security
- Naval Criminal Investigative Service
- Family Advocacy Representative
- Ombudsman
- Red Cross
- Civilian Community Resources (e.g., Department of Social Services, Child Protective Services Unit, mental health service providers, private practitioners, etc.)
- Emergency Medical Technicians (EMT)
- Counseling & Assistance Center (CACC)
- Command Duty Officer (CDO)
- Judge Advocate General (JAG)
- Navy Marine Corps Relief Society
- Local Police Department

4. BASIC PROCEDURES

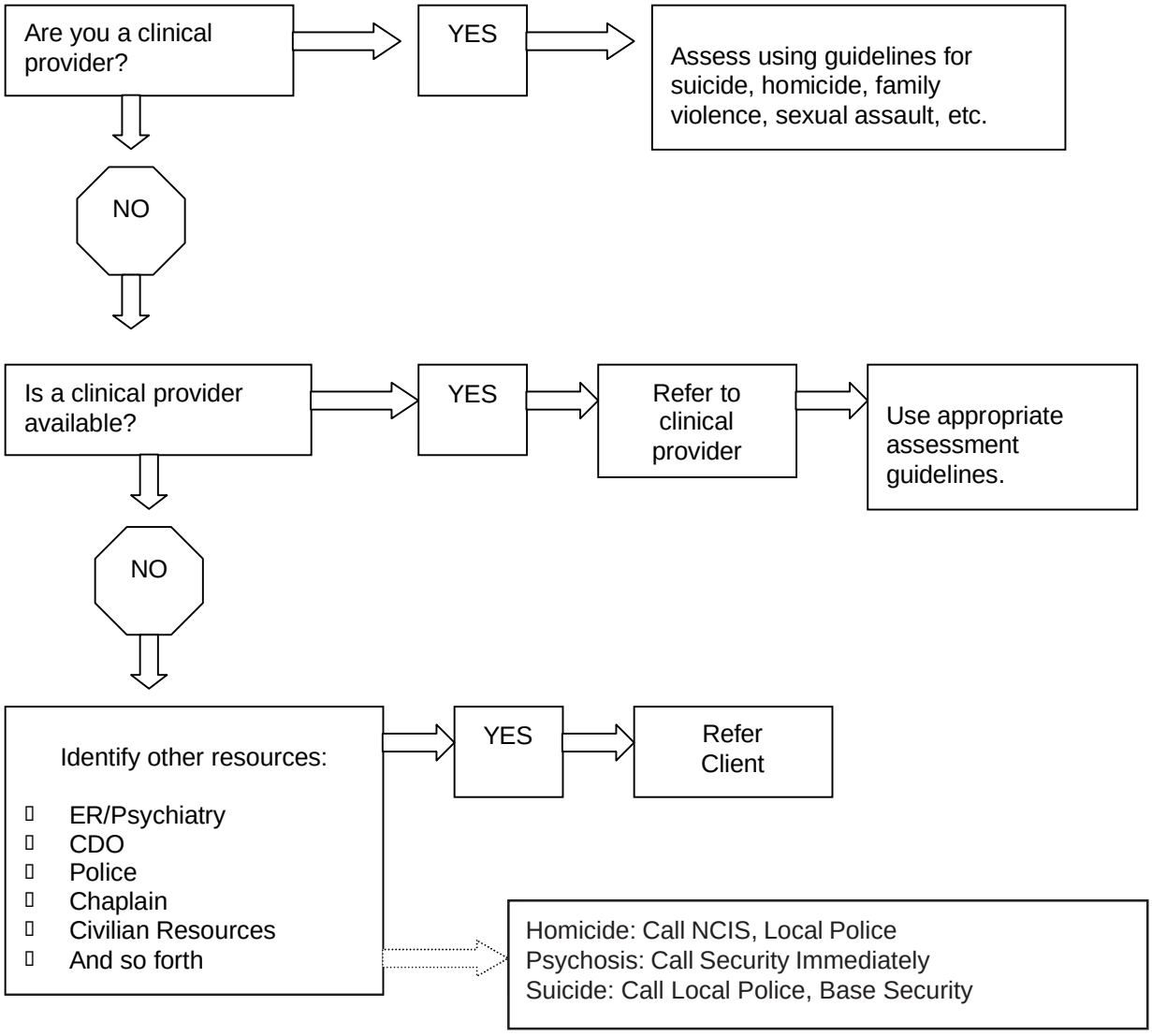
- Assessment
- Intervention
- Follow up

7.1.3.2 CRISIS INTERVENTION PROCEDURES

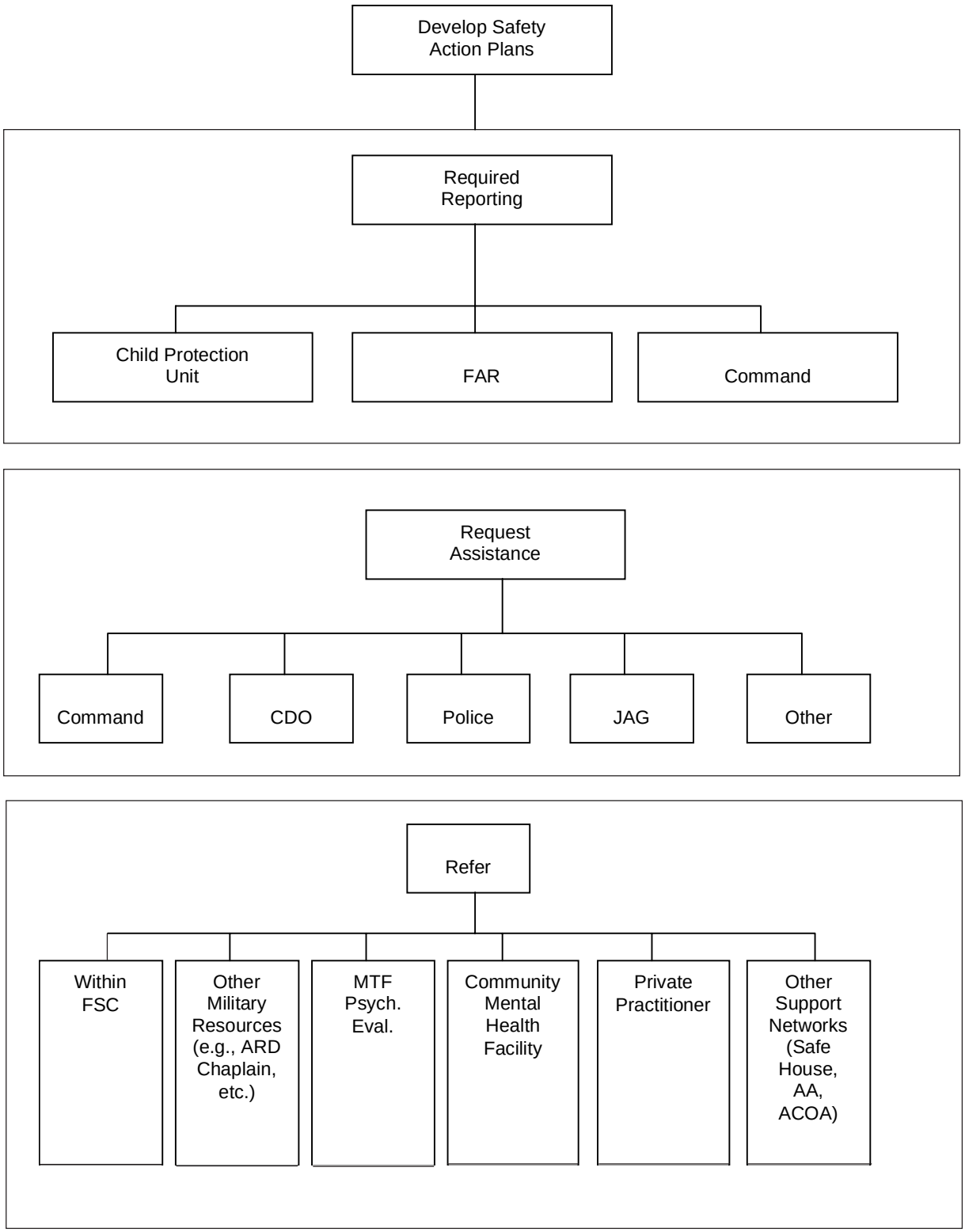
Procedures which should be followed when handling a crisis situation can be broken down into 3 stages:

STAGE I: ASSESSMENT

In all cases, keep the person talking, and remain calm. Get name, phone number, and address.



STAGE II: INTERVENTION



STAGE III: FOLLOW-UP

Follow up with:

- ❑ Agency/POC where incident was reported to.
- ❑ Psychiatry (if psych. evaluation was recommended)

Update disposition of case in record.

Coordinate appropriate support services

Evaluate:

- ❑ Service delivery Stages 1 & 2
- ❑ Effectiveness of safety plan and actions

7.2 PROTOCOL FOR SUICIDE

7.2.1 DESCRIPTION OF BEHAVIOR

SUICIDAL: Inclusive of any person expressing suicidal ideas, thinking of suicide, contemplating suicide, or any person manifesting self-destructive behavior of a life-threatening nature.

SUICIDE: The completion of an act to take one's own life, regardless of the method, which results in the death of the person.

FSC clinical providers are presented with a wide variety of casework situations, which include the threat of loss of life by suicide. All FSC staff (not just clinical providers) should have up-to-date knowledge of the reporting systems and procedures to be followed in the event an FSC client with suicidal intent presents at the center or calls in to the center for assistance.

Privacy Act restrictions do not apply in cases of suicide or life-threatening self-destructive behavior. At the onset of service delivery, clients are informed of the reporting requirements for FSC clinical providers in the event that the client's life is in danger (i.e., client may do harm to himself or herself). The reporting requirements are outlined in the Privacy Act Statement clients sign prior to speaking with a clinical provider.

- The service member's command must be notified immediately after the FSC clinical provider has assessed the client may be a significant danger to himself or herself, with the informed consent of the client if at all possible, without the client's consent if necessary. The purpose is to ensure treatment, access to resources, and to gain command support. Command support is crucial to obtain a psychiatric evaluation/ treatment for the service member. The member must be **escorted** by someone from the command and either screened by the command's General Medical Officer or transported to a local Navy medical clinic or to a civilian hospital for screening.

- Information given to the command should provide a statement about the suicide risk, an intervention plan, and a follow-up plan. Specific details regarding the personal problems related to the suicidal thinking should be limited to provide some privacy for the individual.

7.2.2 ACTIVE DUTY CLIENTS

7.2.2.1 PHONE CALLS FROM ACTIVE DUTY CLIENTS

- If a suicidal client is on the telephone, immediately obtain the following information if possible:
  - Name
  - Phone number
  - Address

- **Assess the immediate lethality.** Ask the client if he or she has a specific plan, method, and/or means (i.e., he or she has ingested pills, has access to a weapon, etc.). Attempt to ascertain if there are any children or weapons in the home. If a substance has been ingested or the individual has done harm to himself or herself, the clinical provider should immediately get another staff person to call for the police/crisis team while the clinical provider KEEPS THE INDIVIDUAL ON THE LINE IF POSSIBLE.

- After assessing lethality, consult with the Clinical Supervisor, in the case of non-privileged providers or, in the absence of the Clinical Supervisor, with the Chief or Clinical Services or another privileged provider (someone should summon a privileged provider to stand by). KEEP THE INDIVIDUAL ON THE LINE IF POSSIBLE, until the danger has passed and lethality is assessed to be low enough to give the client a referral, or emergency help has been called and have arrived on the scene. Privileged practitioners should inform the Chief of Clinical Services and/or the FSC Director of the incident, the actions taken and the outcome, as soon as the imminent danger has passed. This is for the purposes of risk management and not clinical supervision.

- If the situation is not an emergency, the clinical provider should request that the service member see a clinical provider at the FSC to help prepare the individual to access help in the military system.

- Upon arrival at the FSC, follow the procedures for a walk-in active duty client (Refer to Section 2.5.4.2).

- If the client refuses assistance or follow-through appears unlikely, the member's command can be contacted for assistance, however if it is an emergency, the command must be called.

7.2.2.2 WALK IN ACTIVE DUTY CLIENTS

- **ASSESSMENT** of any client will be undertaken by an FSC clinical provider when the client presents suicidal potential on intake or while in clinical counseling at the FSC. The assessment should include immediate consultation with the following:
  - Clinical Supervisor or, in his or her absence, the Chief of Clinical Services or other privileged practitioner, when the assessment is conducted by a non-privileged provider. Privileged practitioners should inform the Chief of Clinical Services and/or FSC Director in a timely manner of the crisis assessment, actions taken and outcome for risk management purposes.
  - Psychiatric staff at the local MTF or, in the absence of a psychiatry service, the duty general medical officer.

- **SUICIDAL POTENTIAL/RISK** should be assessed using standard risk assessment criteria. This should include the following means available to take one's life:
  - Lethality and specificity of plan. If a plan exists, then assume that the more lethal and more specific the plan, the higher the risk.
  - Previous attempts at suicide or suicidal history to include lethality of means used in an attempt, how an attempt failed or was stopped, more than one previous attempt. The more lethal previous attempts were, then the higher the risk (e.g., overdose of aspirin vs. pistol misfired).
  - Situational variables increasing potential such as:
    - Break-up of a relationship
    - Recent loss of spouse
    - Loss of child
    - Loss of more than one family member
    - Loss of employment
    - Other significant loss
    - Anniversary date of loss of significant other
  - Previous suicide(s) in family (e.g., father, mother, brother, or sister committed suicide). A suicide in family history is indicative of higher risk.
  - Demographics: Male, female, age, profession (e.g., single male, 67 years old, without family is considered to be high risk).

- **CRISIS INTERVENTION PLAN.** Non-privileged clinical providers should always consult with their Clinical Supervisor, immediately upon determining that a client presents in imminent danger to self or others. If their Clinical Supervisor is not available, they should consult with the Chief of Clinical Services or another privileged practitioner. Situations of imminent danger to self or other constitute exceptions to the Privacy Act. They should:

  - Notify the member's commanding officer. The command should be requested to provide an escort who will transport the member to the local MTF for psychiatric evaluation and stabilization. The service member's medical record should be forwarded by the command to the MTF, if available.
  - The clinical provider should prepare a written consultation in a sealed envelope and give it to the escort to present to the general medical officer at the MTF.

- **TREATMENT OPTIONS**

  - Hospitalization at local MTF or at a local civilian hospital
  - Outpatient treatment
  - Appointment at Naval mental health clinic for medical/psychiatric evaluation and possible prescription of medication to lift depression
  - Outpatient treatment at Naval mental health clinic
  - 24-hour emergency assistance available through Naval Hospital emergency room and local crisis hotlines
  - Establishing a suicide watch with family members or friends
  - Follow-up clinical counseling at FSC after completion of the mental health evaluation at the MTF or at the local civilian hospital.

7.2.3 FAMILY MEMBERS OF ACTIVE DUTY PERSONNEL

7.2.3.1 PHONE CALLS FROM FAMILY MEMBERS

The assessment procedure is the same for suicidal family members as for active duty members, except they would be transported to the appropriate intake center for referral to a TRICARE-approved mental health provider, or directly to a TRICARE-approved mental health provider or facility (depending on the nature of the emergency).

TRICARE procedures for emergency mental health referral vary by region. It is important to document the specific procedures in your region for seeking emergent referral of family members in the FSC crisis intervention protocol prior to an emergency involving a family member.

There is also no reporting requirement to the service member's command when the situation involves a family member. However, if the service member needs to be contacted to notify him or her regarding the family member's emotional status, the command may become aware of the situation if the member has to be freed from duty.

7.2.3.2 WALK IN FAMILY MEMBER CLIENTS

- **ASSESSMENT.** Assessment procedures for the suicidal family member client are the same as for the suicidal active duty client (Refer to Section 2.5.4.2, Reporting Requirements). The procedures are different in regard to the crisis intervention plan and treatment options.

- **CRISIS INTERVENTION PLAN.** Non-privileged clinical providers should always consult with their Clinical Supervisor, immediately upon determining that the client is in imminent danger to self or others. If the Clinical Supervisor is not available, they should consult with the Chief of Clinical Services or another privileged practitioner.

  - Every effort should be made to contact a family member, friend or neighbor to come to the FSC to assist the client in connecting with an appropriate mental health practitioner. This may involve contacting the command in order for the service member to be freed from duty.
  - Each FSC needs to follow their local intake procedure for referring family member clients to TRICARE-approved mental health providers in the community. This may involve referring the client to an intake center or directly to an approved TRICARE provider. The clinical provider should call the intake center to notify the staff that a client will need their assistance and will arrive shortly.

- **TREATMENT OPTIONS**

  - Hospitalization
    In cases where lethality is high and danger immediate, call for police or crisis

team assistance. Contact the local mental health facility which accepts TRICARE and notify them the client will be arriving shortly.

- Outpatient treatment
  Make a referral to a TRICARE-approved mental health provider.
- 24-hour emergency assistance available through local crisis hotlines.
- Follow up by an FSC clinical provider to ensure that recommended action has been taken and to reassess lethality.

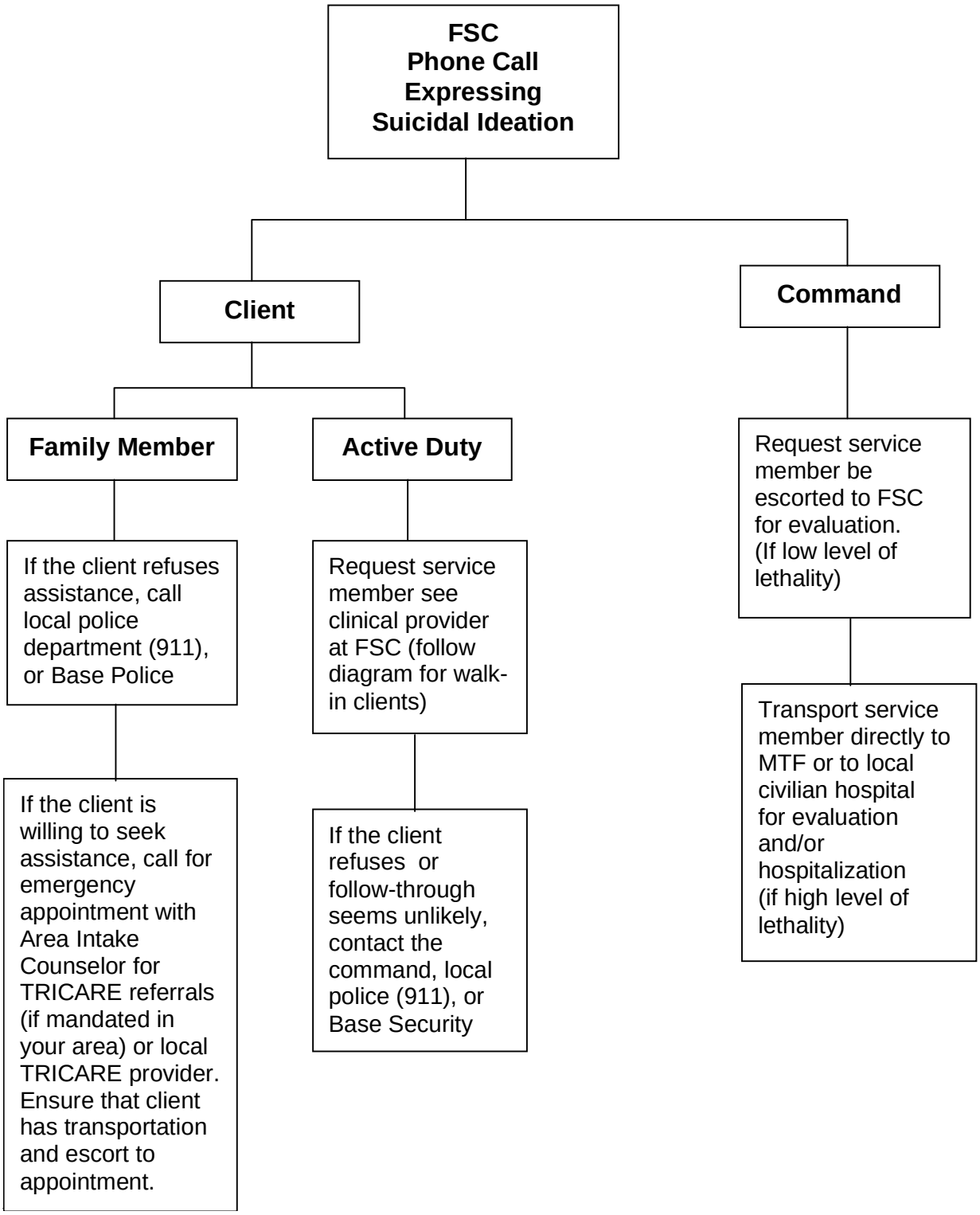
7.2.4 PHONE CALLS FROM COMMANDS

Commands may contact the FSC requesting consultation and assistance regarding a service member with suicidal ideation. A release of information does not need to be signed by the client if the client's life is in danger.

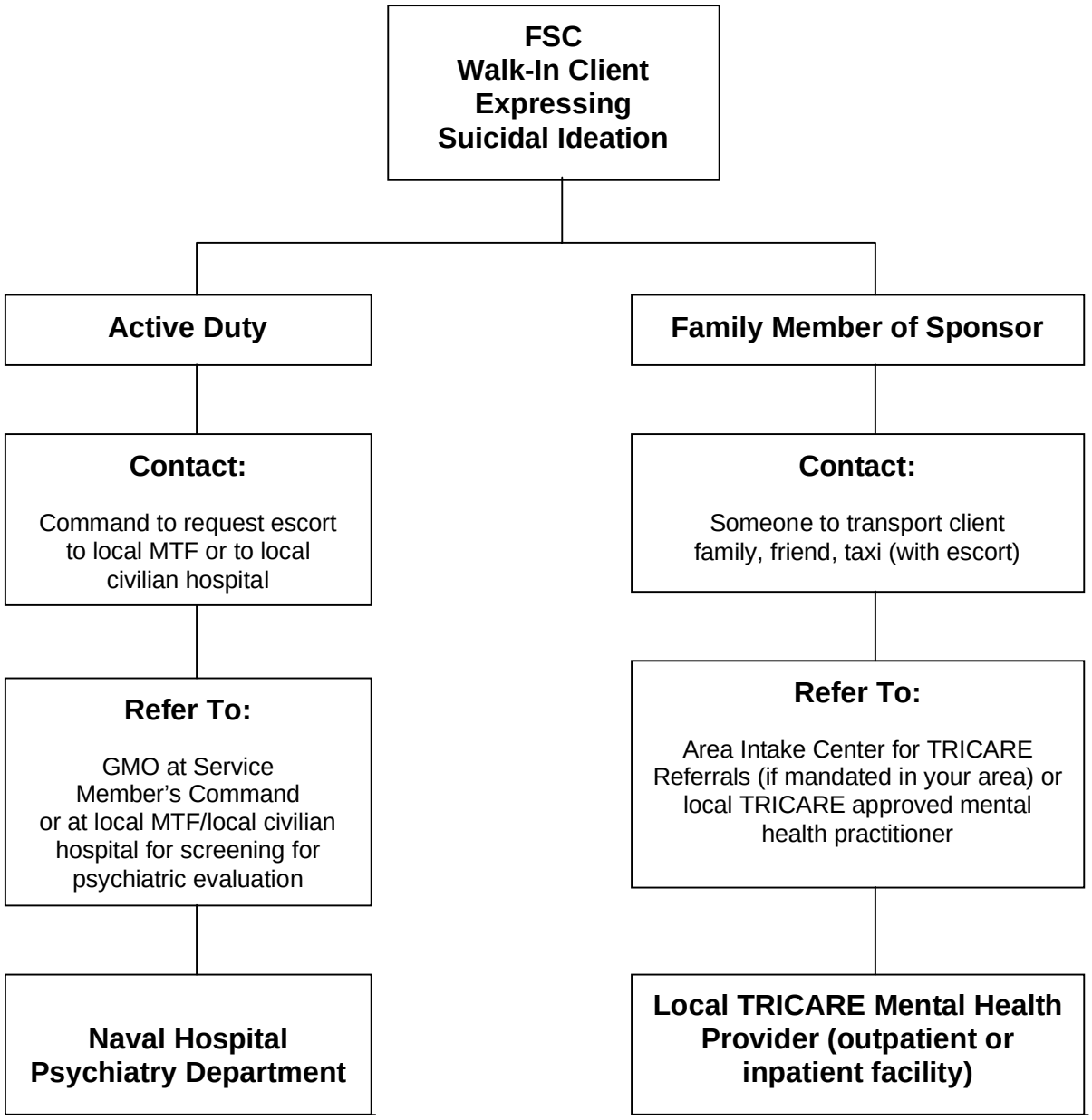
If the situation is an emergency (individual is threatening suicide and may have access to the means), the service member should be referred directly and escorted to the emergency room of the local MTF or to the local civilian hospital.

If the situation is not urgent (warning signs are evident but no threat has been made), the clinical provider should request the service member be escorted to the FSC for an evaluation and/or referral.

7.2.4.1 CASE FLOW CHART FOR SUICIDAL CLIENTS (PHONE CALLS)



7.2.4.2 CASE FLOW CHART FOR SUICIDAL CLIENTS (WALK-INS)



7.3 PROTOCOL FOR HOMICIDE/VIOLENT CLIENTS

7.3.1 DESCRIPTION OF BEHAVIOR

HOMICIDAL: The intent to do harm to others, and/or have potential for violent acting out and is inclusive of any person expressing homicidal ideas, thinking of homicide, contemplating homicide, or any person expressing intent to do bodily harm to another that is of a life-threatening nature.

HOMICIDE: The commission of an act to end another's life, regardless of the method.

VIOLENCE: Exertion of any physical force so as to injure or abuse.

VIOLENT: Behavior characterized by extreme force, marked by abnormally sudden physical activity and intensity.

7.3.2 ACTIVE DUTY AND FAMILY MEMBER CLIENTS

7.3.2.1 ASSESSMENT

The FSC clinical provider must complete a thorough ASSESSMENT of any client expressing homicidal intent. This assessment must include the following elements:

- **Evaluate specificity of plan.** Does the individual have vague thoughts or a concrete plan? Note that the more specific the plan, the higher the lethality.
- **Means of accomplishment.** Does the individual have access to the means; has he or she acquired weapons?
- **Whereabouts of the individual they intend to harm.** Is the individual in the area or available to the client?
- **Past violent behavior.** Does the individual have a history of violent behavior such as fights in school, fights in bars, or domestic violence? Individuals who see violence as a viable option to solving problems are more likely to use violence.
- **Lack of feeling for consequences.** Does the individual appear apathetic or not care what happens as a result of the action they may take? Do they consider the consequences "worth it?" (indicative of high lethality).
- **Lack of impulse control.** Does the individual seem explosive, lack the ability to

handle angry feelings, display a rumination on revenge or the terrible wrong they have suffered? (indicative of high lethality).

Although it may be rare that clients will be violent at an FSC, the clinical provider needs to remain aware of this potential in order to protect his or her safety and the safety of others at the FSC. In order to minimize the risk, the clinical provider must be aware of the client's access to weapons.

No weapons, such as knives used in ship's work, are allowed at the FSC. A clinical provider should leave the room immediately if he or she becomes aware of a weapon and immediately notify the Chief of Clinical Services or his or her immediate supervisor for non-privileged providers. Security should be called to remove the weapon. The client may get the weapon back through security, or the weapon may be retrieved by a designated command representative.

If in the context of the interview it becomes apparent that the client may be potentially violent, the clinical provider should excuse himself or herself. Security should be called for assistance and the Chief of Clinical Services and FSC Director informed. The client should not be provoked. The clinical provider should not sit where access to escape can be blocked. If for any reason the clinical provider is uncomfortable, he or she should consult with the Chief of Clinical Services or his or her immediate supervisor for non-privileged providers before seeing the client or immediately upon sensing danger. At no time is the clinical provider to compromise his or her personal safety.

7.3.2.2 WARNING THE INTENDED VICTIM

If, in the course of clinical counseling, a clinician should become aware of a client's intent to do serious bodily harm to another, he or she is required by law (Tarasoff Decision) to exercise his or her duty to warn. This situation represents an exception to the Privacy Act statement.

Since 1976, a series of cases has firmly established the liability of psychiatrists, psychologists, probation officers, and social workers for the failure to warn third parties of a clearly recognized danger. The most widely known of these cases is Tarasoff V. Regents University of California. In that case a University of California student, who was a psychiatric outpatient at a University clinic, followed through on his threat, previously expressed to his therapist, to kill a specific victim. The Supreme Court of

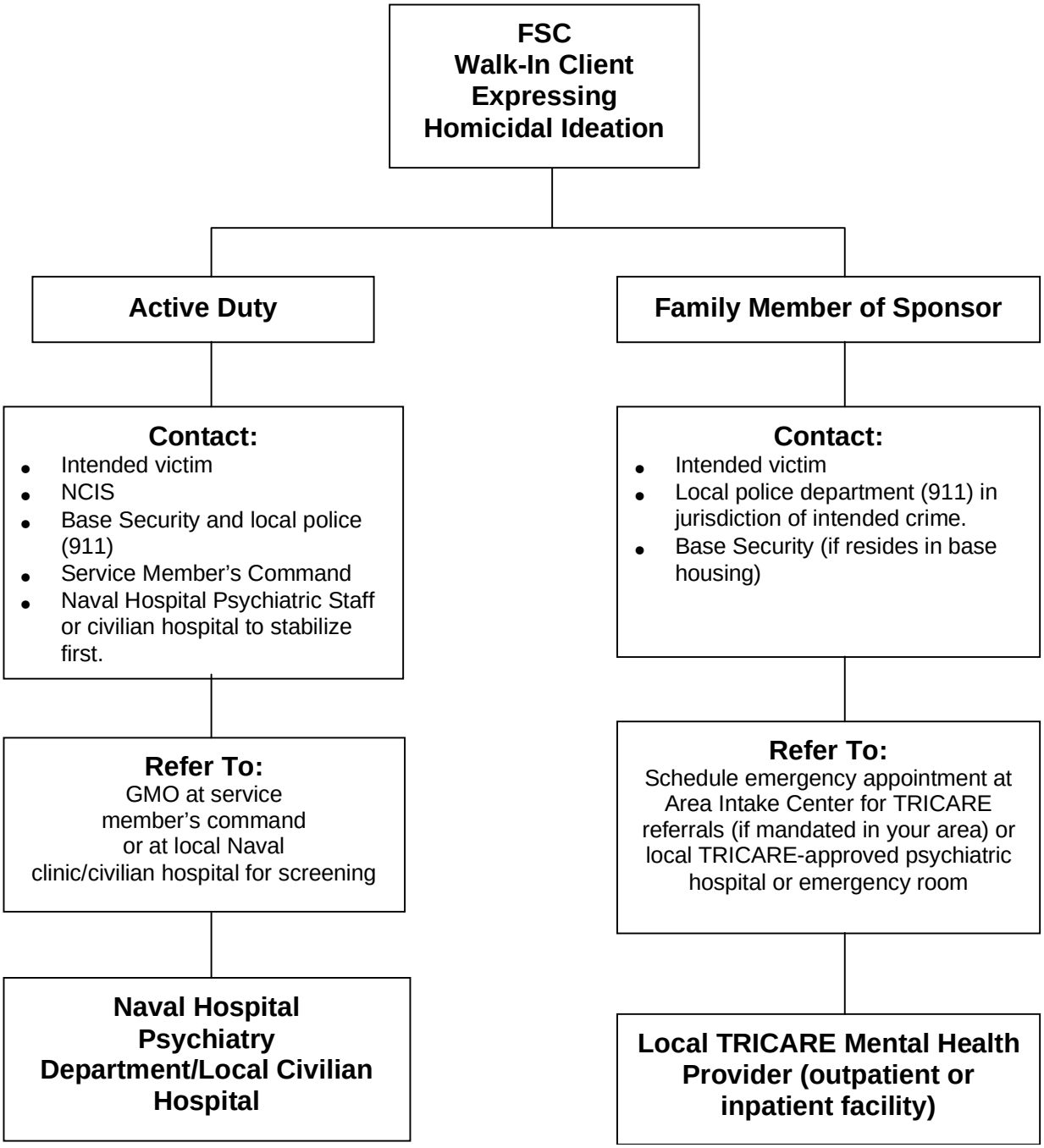
California, in a suit by the victim's parents against the University and its therapists, ruled that a psychotherapist owes a duty of reasonable care to third persons who may be intended victims of the therapist's patient. In the Supreme Court's words:

When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.

A FSC clinical provider must also inform the following individuals:

- The Chief of Clinical Services (if the Chief of Clinical Services is unavailable, then the clinical provider must inform his or her immediate supervisor. For non-privileged providers, this is their Clinical Supervisor).
- The FSC Director.
- The service member's command (if client is active duty) must be informed, with the client's consent if possible, but without the client's consent if necessary. Privacy Act restrictions do not apply in the case of life-threatening behavior. Commands should be notified as soon as possible. Command involvement is crucial in providing social control limits and in assuring immediate treatment intervention for the client. It may also be necessary to assure the continued security and safety of the members of the command. Refer to Section 2.4, Exceptions to Confidentiality in the Military Community, for further clarification.
- Psychiatric staff at the MTF/local civilian hospital, with an evaluation arranged via the command.

7.3.2.3 CASE FLOW CHART FOR POTENTIALLY HOMICIDAL CLIENT



7.4 PROTOCOL FOR FAMILY VIOLENCE

Refer to Part 6, Family Advocacy Program.

7.5 CRISIS INTERVENTION PROTOCOL FOR SEXUAL ASSAULT

SECNAVINST 1752.4 (1996) and OPNAVINST 1752.1A (1998) address the Navy's Sexual Assault Victim Intervention (SAVI) program. Their purpose is to issue policy, provide guidance, and designate responsibility for implementation of the SAVI program. Sexual assault/rape is a criminal act incompatible with the DoN's core values, high standards of professionalism, and personal discipline. The goal of the DoN SAVI program is to eliminate sexual assault incidents, which impact DoN personnel and family members, through awareness and prevention, education, and provision of the safest possible installation environments.

There are three components of the SAVI program which are implemented at all installations and their commands:

- Sexual assault awareness and prevention education
- Victim advocacy
- Data collection

Installation commanders shall designate a SAVI program coordinator to oversee the program. The person is usually located in the FSC. In addition, each command shall appoint a SAVI POC on a collateral duty basis who will ensure prevention education, victim advocacy, and data collection are carried out for the command. SAVI instructions, information, and policy are provided in the SAVI Program Guide, available through the SAVI program coordinator (Refer to Attachments 39-40).

7.5.1 FAMILY SERVICE CENTER ROLES

SECNAVINST 1752.4 and OPNAV 1752.1A clearly state the "Primary mission of the FSC when responding to a victim of sexual assault is to provide immediate support and clinical counseling assistance, and assess the current needs of the victim."

While the FSC's role is the education and prevention component of the SAVI program, FSC clinical providers work collaboratively with their SAVI program coordinator who will be a referral source for the clinical provider. SAVI also provides information and policy

guidance for use by the clinical provider. FSC clinical providers need to be familiar with the SAVI Instructions (SECNAVINST 1752.4 and OPNAV 1752.1A) and with victim's rights.

The FSC clinical provider's responsibilities include:

- Responding to calls from victims, base security, MTF, quarterdeck, or other official sources.
- Providing clinical counseling and referral assistance to victims as needed/requested.
- Providing victims with information on victim's rights and the availability of long-term clinical counseling, shelter, and legal and medical services.
- Providing victims with options concerning their involvement with investigative/legal personnel.
- Completing the Sexual Assault Incident Report/Data Collection Form (if you have knowledge of an incident or a reported incident). Only demographics are put on the form - there is no identifying data put on the form. (Refer to Attachment 39).

In addition, the FSC clinical provider will:

- Ensure the victim is reasonably protected from the accused offender.
- Encourage the client to seek medical attention, for a recent sexual assault incident, regardless of whether the victim requires emergency or nonemergency care.
- Notify the on-call victim advocate, when requested by the victim and determine and comply with victim's preference concerning gender of the advocate when possible.
- Advise the victim the FSC is required to report the incident to Navy/military law enforcement officials if the incident occurred on property under DoN jurisdiction.
- Notify NCIS immediately if the sexual assault occurred on property under DoN jurisdiction. If the assault occurred on property not under DoN jurisdiction and the offender is not affiliated with the Navy, the victim may choose whether or not to notify civilian law enforcement officials. If the victim chooses, FSC personnel can make the initial contact on behalf of the victim.
- Provide the victim with options concerning his/her involvement with investigative/legal personnel. Advise the victim he/she has the right not to be interviewed or press charges. Possible options include:
  - The victim may refuse to be interviewed; then a FSC clinical provider or victim

advocate reports to NCIS, providing a summary of information to the investigative agent.

- The victim may agree to be interviewed with a FSC clinical provider and/or the victim advocate present during NCIS interviews.
- The victim may agree to be interviewed without assistance.

- Provide the victim with a copy of Victim's Rights (Refer to Section 7.5.2). Refer the victim to appropriate legal authorities if the victim has questions regarding his/her rights.
- Notify NCIS of all sexual assault incidents.
- Understand the regulations concerning a victim's legal rights and obligations. Victims are **NOT** required to:
  (a) grant an interview with NCIS;
  (b) file a report/press charges; or
  (c) testify in court.
- Inform the victim the medical command is required to notify military law enforcement of the incident.
- Provide individual clinical counseling if requested by the victim.

7.5.2 VICTIM'S RIGHTS

In 1990, the Office of the Attorney General of the United States declared that although "millions of Americans are victimized by crime every year, recognition of crime victims' rights is a recent phenomenon. Until recently, the protection of offenders' rights took precedence over those of the innocent victims of crime."

With increased focus on those whose lives are harmed by crime, state and Federal legislation has been enacted to protect and maintain the rights of crime victims. Landmark in this legislation is the Victims' Rights and Restitution Act of 1990 (reference (g)) which sets forth the "Rights of Crime Victims."

To ensure the fair and sensitive handling of all sexual assault cases, personnel at every level of victim assistance working with sexual assault victims shall, where possible, ensure the following rights for the crime victim are maintained.

The crime victim has:

- The right to be treated with fairness and with respect for the victim's dignity and

privacy;

- The right to be reasonably protected from the accused offender;
- The right to be notified of court proceedings;
- The right to be present at all public court proceedings related to the offense, unless the court determines testimony by the victim would be materially affected if the victim heard other testimony at trial;
- The right to confer with trial counsel and the staff judge advocate general to the convening authority in the case;
- The right to receive available restitution; and
- The right to information about the conviction, sentencing, imprisonment, and release of the accused.

It is recommended a copy of these rights be provided to all victims reporting sexual assault.

It should be emphasized and explained to victims that federal departments are required to "make their best efforts" to afford victims these rights and to honor them. In addition, the rights listed do not create a cause of action or defense in favor of any person arising out of failure to accord a victim the rights enumerated. Adherence to these guidelines will be in accordance with the legitimate needs of U.S. Navy, the maintenance of good order and discipline, and military situations demanding immediate actions.

7.6 CRISIS RESPONSE/DEBRIEFING

FSC clinical providers may provide crisis intervention with groups of people, which can involve working closely with commands after a traumatic incident has occurred. Incidents can include a fire or explosion on board a ship in which crew members are injured and/or killed, a plane or helicopter crash resulting in injuries and/or fatalities, a situation such as Operation Desert Storm, or a command death/suicide. Crisis requires a variety of skills including working one-on-one with family members of active duty personnel; facilitating group crisis debriefing sessions with commands as well as family members; and training other community professionals to assist military families (e.g., guidance counselors working with children of service members injured and/or killed).

The following Critical Incident Stress Debriefing Training SOP included in this section was specifically developed to prepare FSC clinical providers for crisis intervention in

situations which are directly related to the Navy's many missions.

This manual is for information only. FSC clinical providers interested in receiving training to prepare them to conduct Critical Incident Stress Debriefings should contact the organizations in Part 7.7: Resources. Material regarding information on stress and trauma and how to recognize and deal with it in the crisis intervention process is included.

NAVY FAMILY SERVICE CENTER
STANDARD OPERATING PROCEDURE

I. **Title**: Critical Incident Stress Debriefing (Crisis Debrief) Training

II. **Date**: _____

III. **Background and purpose**: Tragedies, deaths, serious injuries, hostage situations, threatening situations – these events are known as "Critical Incidents." In recent years, Navy Family Services Centers have assisted numerous commands to restabilize in the aftermath of various large and small-scale tragedies. These have included war, ship and aircraft accidents, fires, and tragic member(s) deaths.

Literature on the crisis state emphasizes the importance of intervening to facilitate successful resolution of functioning in the aftermath of a crisis event. Skillful intervention and support to commands requires that Clinical staff be trained to provide these services.

Critical Incident Stress Management (CISM) represents an integrated "system" of interventions which is designed to prevent and/or mitigate adverse psychological reactions that so often accompany emergency services, public safety, and disaster response functions. CISM interventions are especially directed towards the mitigation of post-traumatic stress reactions.

IV. **Target Population**: This training is targeted for clinical staff of Navy Family Services Centers. Crisis Debriefs are targeted to groups of active duty personnel and/or their family members who have experienced and survived a traumatic event within the past 48-96 hours.

V. **Program Objectives**: Participants undergoing this training will be able to:

1. reiterate the normal phases of crisis
2. denote and describe normal socio-emotional responses to crisis
3. cofacilitate the program with crisis victims
4. name two self-care actions facilitators can take during crisis work

VI. **QOLMISNET**: This program is designed for FSC staff professional development. Its presentation is not reportable in QOLMISNET. Debriefing a specific group is reported in QOLMISNET with Program Name "Crisis Debrief," Category "Skills for Living," and Subcategory "Other."

VII. **Quality Control**:

1. Annual revision of the SOP
2. Completion of Presenter Self-Evaluation at each presentation
3. Obtain participant evaluations each presentation

VIII. **Content**: Curriculum outline is attached.

IX. **Required Materials**:

1. Transparencies
2. Overhead projector and screen
3. Handouts:
   - Emotional Aftershocks of Disaster
   - Crisis Intervention
   - Coping Strategies for Children
   - Suggestions for Living Through Trauma
   - How Your Can Help/Remember to Take Care of Yourself

X. **Bibliography**:

1. Mitchell and Everly, Critical Incident Stress De-briefing: CISD An Operations Manual for the Prevention of Traumatic Stress Among Emergency Service and Disaster Workers, 1997

2. http://www.icisf.org/totry.htm (1999)
Recommended activities to try for critical incident stress mitigation.

3. Gilliland, Burle E. and James, Richard K., Crisis Intervention Strategies, Third Edition, 1997

4. Carlson, Eve B., Trauma Assessment - A Clinician's Guide, 1997

XI. **Attachments**:

1. Curriculum outline
2. Handouts - Please refer to Attachments 41-46
3. Presenter Self-Evaluation - Please refer to Attachment 48
4. Participant Evaluation

CRISIS DEBRIEF TRAINING
CURRICULUM OUTLINE

I. Introduction

Critical Incident Stress Debriefing (Crisis Debriefing) and its parallel intervention post-traumatic stress defusing are interventions designed specifically for the prevention of post-traumatic stress and PTSD among high-risk occupational groups such as fire fighters, emergency medical personnel, law enforcement personnel, public safety, dispatch personnel, and disaster workers. The recently modified CISD appears especially suited for mass disasters and community response applications. This model has been adopted by the Navy's Special Psychiatric Rapid Intervention Team (SPRINT) who are frequently deployed to respond to Naval disasters including the USS IOWA explosion, aircraft accidents, shipboard fires, etc. The SPRINT team invited NFSC personnel to attend a two day training in April of 1991 in order that NFSC personnel could assist with local Crisis Debrief interventions. This curriculum outline is a condensed version of that training provided by the National Organization of Victim Assistance (NOVA).

II. Stress and Trauma

A. Your Day-to-Day Life: Individuals exist in a normal state of "equilibrium" or balance. That emotional balance involves everyday stress, both positive and negative - like being late to work, getting a promotion, having a flat tire, etc. Occasionally stress will be severe enough to move an individual out of that state of equilibrium, and into a state of depression or anxiety. Most people stay in a familiar range of equilibrium.

B. When Trauma Occurs: Trauma throws people so far out of their range of equilibrium that it is difficult for them to restore a sense of balance in life. Trauma may be precipitated by stress: "acute" or "chronic".

1. Acute stress is usually caused by a sudden, arbitrary, often random event.

2. Chronic stress is one that occurs over and over again - each time pushing the individual toward the edge of his/her state of equilibrium, or beyond.

Most trauma comes from acute, unexpected stress like crime, natural disasters, accidents, acts of war, etc.

C. Issues predicting high or low risk for trauma:

1. Duration of the event - the longer the crisis, the greater the trauma

2. Extent of carnage and injury.

3. Amount of financial and material loss.

4. Extent of death. More trauma associated with large number of deaths.

5. Extent of sensorial involvement - burning smells, destruction, sights and sounds compounds reactions.

6. Perceived possibility of reoccurrence - anger and fear.

7. Duration of rescue.

8. Previous coping ability and skills.

III. Crisis Reaction

A. Background:

Recognizing Critical Incident Stress: Critical incidents may produce a wide range of stress symptoms, which may appear immediately at the scene, a few hours later or within days of the incident. Stress symptoms usually occur in four different catagories: Cognitive (thinking), Physical (body), Emotional (feelings), and Behavioral (actions). The more symptoms experienced, the more powerful the stress reaction. The longer the symptoms experienced, the more potential there is for lasting harm. The following is only a sample of stress symptoms that can show up after a critical incident.

Cognitive	**Emotional**
poor concentration memory problems poor attention span difficulty making decisions slowed problem solving difficulties with calculations	guilt grief depression anxiety/fear loss of emotional control feelings lost/overwhelmed
Physical	**Behavioral**
muscle tremors chest pain gastro-intestinal distress difficulty breathing headaches elevated blood	excessive silence sleep disturbances unusual behaviors changes in eating habits

1. Individuals exist in normal state of equilibrium.

a. You establish your own boundaries, usually based on a certain order and understanding of the world.

2. Occasional stressors will move the individual out of the state of equilibrium but most people most of the time stay in a familiar range of equilibrium.

3. Trauma throws people so far out of their range of equilibrium that it is difficult for them to restore a sense of balance in life. And when they do establish a new sense of balance, it will be different than prior to the trauma. It will have new boundaries and new definition-some can't handle as much stress after-some more flexible.

4. Trauma may be precipitated by an “acute” stressor or many “chronic” stressors.

a. An acute stressor is usually a sudden, arbitrary, often random event.

- stranger crime
- natural disaster
- man-made disaster
- accidents
- acts of war

b. A chronic stressor is one that occurs over again-each time pushing the individual toward the edge of his state of equilibrium, or beyond.

- chronic child, spouse, or elder abuse
- chronic illness
- developmental “crises”: come from transitions in life, like adolescence, marriage, parenthood, and retirement
- planned “crises”: beginning an advance degree, accepting a new job, planning a vacation

c. Though similar to acute stress, chronic and developmental crises have significant differences not covered in this review. They are important to note because they affect the pre-existing equilibrium before an acute stressor occurs. An individual suffering severe chronic stress may be more vulnerable and at a higher risk for emotional trauma after an acute stressor.

B. Physical Response: Physical response is based on our animal instincts. You have little control over your immediate response.

1. Physical shock, disorientation, and numbness: “frozen fright” shows a psycho-physiological incapacity to acknowledge a dangerous threat.

2. “Fight-or-flight” instinct: the psycho-physiological response to feelings of danger that are acknowledged. Have little or no control over even to training.

3. Physiological reaction to fight-or-flight instinct:

a. adrenaline begins to pump through body

b. body may relieve itself of excess materials regurgitation, defecation, or urination.

c. heart rate increases

d. hyperventilation, sweating, etc.

e. heightened sensory perception in at least one sense: smell, taste, sight, hearing touch

4. Heightened physical arousal associated with fight or flight cannot be prolonged indefi-

nitely. Eventually it will result in exhaustion - getting on with life critical part for depression.

C. Emotional Reaction: Emotional reaction is heightened by physical response. Follows physical reaction.

1. Stage One: shock, disbelief, denial. This stage may last for only a few moments or it may go on for months. Survivors of homicide or sudden death victims often talk about walking in a daze for years. Denial-can as repression. ex: chronic abuse.

2. Stage Two: cataclysm of emotions. (Note to trainers, the following sequence of explanations is often the most useful in training sessions.)

a. anger or rage. The anger may be directed at God, human error, the assailant(s), family members, the criminal justice system, and even oneself. Not everyone feels anger, but many people do. It may become confused in the aftermath of a crime with revenge and the desire for vengeance. Just as anger or rage is a normal human response so is the desire for revenge. But, for many that desire subsides even though overwhelming rage may remain.

- Many times directed at the "helper"
- Directed at Navy (accusations of poor maintenance on USS Iwo Jima.)

b. fear or terror. In the aftermath of a catastrophe that involves life threatening injury or death, there is usually a sense of terror. Many people talk about having seen their own death, and the fear of that death is intense. Terror is also a residual emotion that emerges from the physical response of panic. It may become the foundation for panic attacks in the future.

- fear of being in work space after accident helps incorporate some caution, prevention

c. frustration. Frustration is a by-product of the feelings of helplessness and powerlessness during the actual impact of the disaster. In the aftermath of the impact, it continues when rescuers or the victims or survivors are unable to successfully obtain needed help.

d. confusion. Confusion stems from the "why me?" question that plagues most victims. It is a question that usually has no answer. However, we tend to seek order and rationality in the world, and so the unanswered question causes more frustration. Often in the effort to establish an answer, victims turn inward and blame themselves for the crisis.

e. guilt of self-blame. These emotions often have two aspects. The first feelings of guilt or self-blame may result from the mind's effort to understand the event and hence identifying behaviors or attitudes through which the victim brought the even upon himself. Another type of guilt is known as survivor guilt. Victims often are plagued with internal questions about why they survived while others died. They may think themselves unworthy of survival or may feel guilty because someone chose to save them while another person died.

f. grief or sorrow. Intense sadness over losses is not uncommon. The kinds of losses are described later. Loss of: identity, trust, faith, past loss of parent, loss of child, changed person.

3. Stage three: Reconstruction not recovery of equilibrium is different emotional rollercoaster that eventually becomes balanced.

a. a new equilibrium is established

b. a different equilibrium

c. that reconstruction can be very difficult and take a long time

d. it includes living through bad days and then good days

IV. Acute Stress Reactions

A. Physiological Reactions:

Fatigue	Headaches
Nausea	Stuttering, speech difficulties
Muscle tremors	Insomnia
Twitches	Loss of appetite
Shock	Bruxism (teeth grinding)
Profuse sweating	Pounding of the heart
Chills	A lump in your throat
Dizziness	Trouble getting your breath
GI upset	Easily startled
Other	

B. Cognitive Reactions:

Memory loss	Unwanted thoughts
Loss of decision making ability	Trouble concentrating
Derailed problem solving	Mind going blank
Confusion of trivial with major items	Loss of attention span
Calculation difficulties	Partial amnesia about the trauma

C. Emotional Reactions:

Anxiety	Apathy
Fear	Urge to cry or run and hide
Grief	Nightmares
Depression	Feelings of unreality
Hopelessness	Nervous laughter
Irritability	Anger
Feeling overwhelmed	Identification with victims

D. Behavioral Reactions:

Marital problems	Over or under eating
Anger outbursts	Increased smoking
Suicide	Alcohol or drug abuse
Decreased job performance	Emotional withdrawal
Quitting	Accident proneness
Other	

E. The severity of the crisis reaction is affected by:

a. intensity and duration of the trauma

b. suddenness of its occurrence

c. stability of the person's life prior to the trauma

d. personal history of prior losses/traumas

e. availability and use of social support

f. ability to understand what has happened

F. Recovery: It is common for people to resist acknowledging the need for psychological assistance in the aftermath of a trauma. However, most people find some kind of benign outside intervention useful in dealing with trauma. Recovery issues for survivors include:

a. getting control of the event in the survivor's mind

b. working out an understanding of the event and, as needed, a redefinition of values

c. re-establishing a new equilibrium/life

d. re-establishing trust

e. re-establishing a future

f. re-establishing meaning

Most individuals can expect a substantial amount of recovery within several months of the trauma. Many survivors may continue to re-experience crisis reactions over long periods of time. These reactions usually occur following a "trigger event" (e.g., anniversaries of the trauma; anything that reminds the survivor of the trauma — such as sights, sounds, smells, etc.). The intensity and the frequency of these reactions usually decreases over time.

V. Key Steps to Successful Debrief

A. Initial Contact:

1. Information gathered from all sources (Navy, CNN, Command Key Leadership, other)

2. Team leader calls medical officer, CO, XO, or other key leadership personnel

3. Services explained, assistance offered

4. Advice and consultation are provided

5. Invitation obtained

B. Intervention Planning:

1. Meet with Commanding Officer
2. Reinforce practical suggestions
3. Educate, explain, reassure - establish credibility
4. Obtain permission and support
5. Meet with Executive Officer. Tour spaces. Get a feel for what happened.
6. Identify affected groups (proximity, relationships, kind of exposure)
7. Schedule debriefings, locate spaces, set ground rules

C. Formal Debriefing:

1. 90 minutes to 3 hours
2. Structured
3. 24-72 hours after incident, in special cases - up to 8 weeks is acceptable
4. Please see attached outline (Addendum #1)

D. Follow-up Debriefing:

1. Monitor for the need and carefully time the intervention
2. Be reluctant to return, wait for objective signs that a follow-up debrief is necessary
3. Encourage command to get back to work despite objections
4. Expectation of recovery

E. Individual Consults:

1. If less than 3 affected
2. Individuals with reactions beyond the norm
3. Workers removed from the scene
4. VIPs

F. Memorial Service

G. Outbrief with Commander: vague with personal details, but he/she should know if one or two individuals having particular problems to ensure safety.

H. Caring for the Team Members:

1. Debrief the debriefers

2. Education/ongoing training

3. Regular team meetings

4. Know your limits - take care of yourself!

5. Time out

6. Monitor each other

CRISIS DEBRIEF

ADDENDUM #1

CRISIS DEBRIEF INTERVENTION STEPS

Stage 1:	Introduction Phase (C)	To introduce intervention team members, explain process, set expectations.
Stage 2:	Fact Phase (C)	To have each participant describe the nature of their participation, from a cognitive perspective.
Stage 3:	Thought Reaction Phase (C-E)	To solicit cognitive response to: "What aspect held the most negative impact?" or, "What aspect was the worst for you?" Then, transition from cognitive to emotional processing.
Stage 4:	Emotional Reaction Phase (E)	Given the response to Stage 3, to solicit emotional reactions or consequences.
Stage 5:	Reframing Phase (E-C)	To transition from emotional domain back to cognitive. "What lessons could be learned from this experience?" and, "What is something positive that you will take away from this experience?"
Stage 6:	Teaching Phase (C)	To educate as to normal reactions and teach basic stress management, if applicable.
Stage 7:	Re-Entry Phase (C)	To summarize experience with emphasis on positive or learning aspects.

C=Cognitive
E=Emotion

APPENDIX A

THE INTRODUCTION

THE FOLLOWING INTRODUCTION CAN BE WRITTEN ON ONE SIDE OF A 3X5 INDEX CARD AND THE PHASES OF THE INTERVENTION CAN BE WRITTEN ON THE OTHER SIDE.

Introductory Statements:

1. We are here because something awful has just happened.
2. I am _____. I am here because I believe I can be useful to you. I have training and I have worked with other people in similar situations. Express your sympathy for the loss of their colleague, shipmate, etc.
3. What you just experienced was unpleasant, we want to keep it from harming you.
4. If you talk, you will be less likely to be harmed.
5. I am not part of any investigation.
6. I will hold what you say in the strictest confidence.
7. There is no mandatory sign in sheet.
8. There will be no formal report to your command.
9. You all have to make a confidentiality pact. You can not talk about other people's experience after this debriefing is over.
10. Don't talk about legal issues, I don't want to know.
11. I may have to prepare an after action report, but no details of the debriefing will be written down.
12. We want you all to be able to sleep, to eat, and to have less nightmares. Even if you feel fine now, I wish you would stay. Something you say could help me deal with others in the future.
13. Does anyone have an issue with being here? Was anyone ordered in? You're here, I'm here, let's make the best of this.
14. This is going to be an interchange. Please ask me questions, pick my brain.
15. We don't take a break. You can leave to use the head, but please return.
16. I will only ask you to speak once and then only to say who you are, your job, and what happened.
17. Please talk only about yourself - No one else.

Debrief/Phases of Intervention:

1. Where were you when you heard? Who were you with?
    - Validate reactions and emotional experiences
    - Normal reactions to abnormal situations
    - This loss may raise issues/increase sensitivity to your own losses
    - "Survivor guilt"
    - Emotions: Shock, disbelief/denial, anger/rage, fear, grief, guilt, confusion, return to equilibrium
    - Roller coaster of emotions
    - Predict reactions - guilt and fear predominate often up to 6 months after; difficult anniversaries - 1 to 2 years
2. How are you coping with the stress?
3. What possible memorial plans might you participate in?
4. Your reactions are all normal reactions to abnormal situations!

CRISIS DEBRIEF

ADDENDUM 2

CHILD REACTIONS TO TRAUMA

I. Overview: Children's reactions to a trauma will involve not only the impact of the catastrophe on their lives (what they saw, heard, felt, smelled, and so on) but a sense of crisis over their parents' reactions. The presence or absence of parents and terror over a frightening situation-one that has rendered the children's parents helpless-all contribute to children's distress.

"A central theme that emerges from exploration of children's responses to disaster situations is that, in a way that is not generally appreciated, they, too, experience fear of death and destruction...Particularly influential in the young child's experience are the presence or absence of his parents and the terror of overwhelming physical forces that seem to render the "all powerful" adult parents frightened and powerless."

A. Birth-2 Years

1. High anxiety levels manifested in crying, biting, throwing objects, thumb sucking, and agitated behavior.

B. 2 Years-6 Years: pre-school - talk in terms of feelings. Most children don't remember events until 4 or 5 years-those who remember earlier-it's usually a trauma.

1. Children may not have the same level of denial as do adults so take in the catastrophe more swiftly.

2. Engage in re-enactments (get them to play out as much as they can-the way adults talk it out) and play about the traumatic event-sometimes to distress of parents or adults. Ask them about it; what does it mean?, do it with them.

3. Anxious attachment behaviors are exhibited toward caretakers-may include physically holding on to adults; not wanting to sleep alone; wanting to be held.

4. May become mute, withdrawn and still. Key-change in child.

5. Manifest a short "sadness span" but repeat sadness periods over and over.

6. Regress in physical independence-may refuse to dress, feed, or wash self; may forget toilet training; may wet bed.

7. Sleep disturbances, particularly nightmares are common.

8. Any change in daily routines may be seen as threatening. (Need continued structure

to provide security.)

9. Does not understand death (no one does) and its permanency-reaction to death may include anger and a feeling of rejection.

- cartoons-temporary death
- as though they did something to cause this-"if they had just put their toys away"

C. 6 Years-10 Years: School Age

1. Play continues to be the primary method of expression, often art, drawing, dance or music may be integrated in the play.

2. The sense of loss and injury may intrude on the concentration of the child in school. May have difficulty staying on task, remembering homework.

3. Radical changes in behavior may result-the normally quiet child becoming active and noisy; the normally active child becoming lethargic (child often feels responsible for what happens in the world around them-if they can change their behavior maybe they can change disaster).

4. May fantasize about event with "savior" ending. See a lot in divorces-Mom and Dad getting back.

5. Withdrawal of trust from adults.

6. May become tentative in growth towards independence.

7. Internal body dysfunctions are normal-headaches, stomach aches, dizziness.

8. May have increasing difficulty in controlling their own behaviors.

9. May regress to previous development stages.

D. 10 Years-12 Years: girls' pre-adolescence
12 Years-14 Years: boys' pre-adolescence

1. Become more childlike in attitude.

2. May be very angry at unfairness of the disaster. Tends to see the world in black and white.

3. May manifest euphoria and excitement at survival.

4. See symbolic meaning to pre-disaster events as omens and assign symbolic reasons to post-disaster survival.

5. Often suppress thoughts and feelings to avoid confronting the disaster.

6. May be self-judgmental about their own behavior.

7. May have a sense of foreshortened future. Their security has been shaken.

8. May have a sense of meaninglessness or purposelessness of existence.

9. Psychosomatic illnesses may manifest themselves.

E. 12/14 Years-18 Years

1. Adolescents most resemble adult post-traumatic stress reactions.

2. May feel anger, shame, betrayal and act out their frustration through rebellious acts in school.

3. May opt to move into adult world as soon as possible-to get away from the sense of disaster and to establish control of their environment.

4. Judgmental about their own behavior and the behavior of others.

5. Their survival may contribute to the sense of immortality.

6. They are often suspicious and guarded in their reaction to others in the aftermath.

7. Eating and sleeping disorders are common.

8. Depression and anomie may plague the adolescent.

9. May lose impulse control and become a threat to other family members and himself.

10. Alcohol and drug abuse may be a problem as a result of the perceived meaninglessness of the world.

11. Fear that the disaster or tragedy will repeat itself adds to the sense of a foreshortened future.

12. May have psychosomatic illnesses.

II. Some Coping Strategies for Children

A. Rebuild and reaffirm attachments and relationships. Love and care in the family is a primary need. Extra time should be spent with children to let them know that someone will take care of them and, if parents are survivors, that their parents have reassumes their former role as protector and nurturer is important. Physical closeness is needed.

B. It is important to talk to children about the tragedy (in their language)-to address the irrationality and suddenness of disaster. Children need to be allowed to ventilate their feelings, as do adults, and they have a similar need to have those feelings validated. Reenactments and play

about the catastrophe should be encouraged. It may be useful to provide them with special time to paint, draw, or write about the event. Adults or older children may help pre-school children reenact the event since pre-school children may not be able to imagine alternative "endings" (rescue safety, during job) to the disaster and hence may feel particularly helpless.

C. Parents should be prepared to tolerate regressive behaviors and accept the manifestation of aggression and anger especially in the early phases after the tragedy.

D. Parents should be prepared for children to talk sporadically about the event-spending small segments of time concentrating on particular aspects of the tragedy.

E. Children want as much factual information as possible and should be allowed to discuss their own theories about what happened in order for them to begin to master the trauma or to reassert control over their environment. Need to be concrete when explaining death-don't give myths ("sleeping").

F. Since children are often reluctant to initiate conversations about trauma, it may be helpful to ask them what they think other children felt or thought about the event.

G. Reaffirming the future and talking in"hopeful" terms about the future events can help a child rebuild trust and faith in his own future and the world.

- Try to avoid talking about despair ("It's going on"-kids don't understand and adult doesn't mean this.)

- OK for them to hear if you're sad

- Find role model close to their age but older-install sense of hope for future. Often parental despair interferes with a child's ability to recover.

H. Issues of death should be addressed concretely.

- Avoid: "sleeping" myth; "sick"/hospital-emphasize VERY sick and most people recover

- Say: religious meaning; changes in body (be concrete) no breathing, seeing, smelling, walking.

CRISIS DEBRIEF

ADDENDUM 3

STRESS REACTIONS OF CAREGIVERS

I. Preparation for Serving as a Caregiver in the Aftermath of a Crisis

A. Mental preparation: you are preparing yourself for surviving chronic, acute trauma.

B. Self-assessment begins now. There is no right answers in this assessment, the important thing is to make the assessment in order to plan how you will deal with trauma.

1. How do you deal with stress?

- Suggestions? Social Work breaks/talk to others

- No matter how you deal with emotional stress, you will suffer physical stress (exhausting/trying work).

2. How do you see your life history and actions? Do you integrate life's components or do you separate them?

a. Are you focused or unfocused in life?

b. Do you work best alone or in groups?

c. Are you more attuned to a manmade or natural environment?

3. Values clarification.

4. Issues examination: carnage, pain, grief, anger, fear, death. Be in touch with own feelings.

5. What area were you most comfortable with: answering phones, comforting families, logistics.

II. Suggestions For Living Through Trauma

A. Physical preparation.

1. Eating habits: need 3 meals! Does junk food exhaust you? O.D. on coffee.

2. Sleeping habits: can you sleep during the day? P.M. shift, how many hours.

3. Exercise: will give you more energy important to find time especially if prolonged.

4. Indulgences: Chocolate M&M's.

B. Creation of a meaning, belief, and value system.

- In what you're doing-it's important

C. Goal or purpose orientation.

- Understand what our mission is

D. Training and preparation for your goals.

- Feel competent and confidant

E. Plan for trauma.

- What we're doing

1. Cultivate support system: educate, reciprocal support, explain, and choose carefully.

2. Time management.

3. Diversify activities; cultivate routines.

4. Information management.

5. Provide your own crises intervention.

a. Establish a safe place for your trauma reactions-with 1 person, group or spouse.

b. Allow yourself to ventilate: exercise, expressive movement, write, talk, feel-get the feelings out! Eventually will come out-misdirected.

c. Predict for yourself when trauma or feelings might be most potent and construct a plan for dealing with them-maybe when alone, driving home.

6. Acknowledge trauma, its successes and failures. Opportunity to grow, learn more about yourself. Strengths/weaknesses.

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ADDENDUM 4

CONCERNS OF SPECIAL GROUPS

I. Victims of Disaster Defined: (Use "The Emotional Aftershocks of Disaster" graphic.)

A. Individuals who took the brunt of the catastrophe; those at the center. There were dead victims, seriously injured victims, victims with minor physical injuries; victims who were not physically injured but were at the center and lost property; witnesses who lost nothing tangible but were at the center of the catastrophe-perhaps witnessing the death of someone else. Some unique issues that may bother this population group include:

1. The inventory and pain of the loss of physical well-being or property.

2. For seriously physically injured victims, there is often a feeling of isolation and abandonment as they are rushed from the scene to a hospital room.

3. Survivor guilt may plague such victims. Why did they survive? Feelings that they should have died instead of some more worthwhile victim (a child, a famous person, and so on.)

4. They may feel confused and guilty over their own sense of pain, loss, grief, and anger. They lived through the disaster and were spared while others died. Yet they still feel terrible. They may think they do not have a right to those feelings because they didn't lose enough.

5. There is relief and euphoria at having survived, but that is in conflict with their sorrow over other's death.

6. They may feel estranged from the disaster because the focus of attention is on the dead and their loved ones, and not on the less injured victims or witnesses.

7. If they were injured only minimally or were witnesses, and were unable to help others, it may compound their guilt and confusion.

8. Often their predominant emotions in the aftermath of the disaster are guilt, anger and fear.

II. Individuals whose loved ones were killed in the disaster. They may include family members, friends, partners, and so on.

A. May be preoccupied with how the victims died-did they feel pain, were they conscious, how long did the pain last?

B. May be angry at the victims who survived and find it difficult to talk to their significant

others. They may wish that other people had died, not their loved one-those wishes tend to make them feel guilty and lowers their self-esteem.

C. They often encounter practical problems in body identification, death notification procedures, funeral arrangements, body transportation, and reclaiming the deceased's property. In some disasters it is impossible to reclaim a body, and they may only reclaim body parts or have nothing to bury or to cremate at all.

D. Anger at God is not uncommon, particular when God spared others and not the loved one.

E. Their imagination of the pain, the anguish, the fear that their loved ones endured may cause horror and revulsion.

F. They may feel guilt at something they did or did not do, when seeing or talking with the victim just before he died (may have had an argument, marital problems).

G. Grief tends to be the predominant emotion. However, for some survivors, their grief is repressed in their anger at immediate problems or the disaster itself.

III. Loved Ones: These Individuals are the loved ones of the victims who survived the disaster.

A. Such individuals usually are greatly relieved that their loved ones survived. The relief is often mixed with gratitude and thankfulness. Sometimes that is translated into appreciation to God.

B. In addition to relief is worry and concern over the loved ones' pain or loss.

C. The worry and concern may be converted to anger. Anger is used particularly by men to mask feelings of fear and helplessness.

D. Loved ones may blame the victim for being involved in the disaster, particularly if there was a warning before the event (or volunteered for duty).

E. These individuals may also be confuses over the victim's lack of jubilation at survival and over many victims' inability to "get over it" (tolerance level-about 6 months, 2nd anniversary most drift).

IV. On-Scene responders

A. Fire fighters

1. Depending on the jurisdiction, these individuals may be the first at the scene of a disaster and may find injury and death. Carnage and dead bodies are often a shock to them and they may feel overwhelmed and helpless by the extent of destruction.

2. They often don't know what they will be assigned to do when they arrive at the scene of a disaster. They may be in charge of distributing food, blankets, or other basic necessities. They may be responsible for setting up emergency facilities at the site. They may be assigned to

a morgue or asked to participate in rescue efforts. They may be unsure of when they will be relieved from duty. Such uncertainty adds to feelings of frustration and dismay.

3. Often red Cross workers receive no emotional intervention following a disaster and may face the problem of long-term stress build up due to multiple catastrophes.

V. Remote Responders

A. This particular group is often left out of any consideration for intervention, because their stresses are viewed to be less intense. However, most of these individuals face working conditions similar to those of the immediate on-scene responders. They work long hours without relief in the midst of chaos. What they do not do is actually visit the site or see the carnage and destruction. However, this may intensify the trauma rather than minimize it. For they, too, may have horrific visions of what happened that are far worse than the actual catastrophe itself.

B. Emergency managers

1. Frustration is a key factor in the stress endured by emergency managers. Often they feel that they could do a better job at the scene of the disaster than employees, yet they must sit in an office and coordinate the total response without a hands-on release.

2. Managers also must deal with the politics of the disaster. Often many jurisdictions are involved in a catastrophe and certainly numerous agencies. Political issues of who is in charge; who does any follow-up investigation; and so forth may create further chaos in the aftermath of the trauma.

3. Managers who are supposed to "be in control" may feel that they are out of control and helpless in their response. They may not have the power or resources to respond effectively.

4. Managers who have employees who are at the scene and get injured or killed in the disaster may feel guilt and sorrow over the victims. They may become preoccupied with questions such as "what if we responded differently?"; "what if I hadn't sent that person on that assignment?"; "Why do I choose to respond in this manner?" (Chiefs and Division Officers).

5. Managers are also pressured in the aftermath of a catastrophe to get their agency or business back to "business as usual." They often feel they must set the standard for their employees by behaving as if the disaster didn't affect them or by taking the lead in doing regular everyday work.

6. Managers may take the brunt of criticism for any perceived mismanaging of the disaster response. May be reprimanded because things didn't go as smoothly as they should have.

7. The pain, exhaustion, and distress of managers is often discounted because they "didn't live through the actual disaster". However, most managers justifiably feel as though they did live through it and many resent the minimalization.

C. Emergency support personnel: This group of responders includes clerical staff, receptionists, I&R and the like. These people are almost universally ignored because "their jobs aren't that important in a disaster". Yet without the support personnel, no effective, coordinated response could take place.

1. Emergency support personnel not only have to deal with the demands of the disaster-telephone calls, responding to people in crisis who are worried about whether their loved ones are involved in the catastrophe, facilitation all communication and the like-they also must maintain "business as usual" during the disaster itself (i.e., I & R - ship number of requests).

2. By the nature of their positions, they may be forced to comfort or soothe individuals in crisis because their loved ones are injured or dead.

3. They often are also thrown into the position of providing such emotional support to on-the-scene rescuers when they return to home base and to the emergency managers.

4. They very often feel helpless in their jobs and accept the public's perception that they are not being useful or important.

5. They may be the target of anger or sarcasm by those calling for help.

6. They may receive little or no information about what is happening during the disaster response, and yet they may be the focus for questions what happened. They often feel left out.

D. Shelter and care givers: those who operated a disaster shelter, or provided food, clothes and other necessities to victims and survivors (work at Family Assist Center, counseling).

1. While these individuals may feel very useful during the immediate aftermath of a disaster, they are often left with a feeling of isolation, estrangement and loneliness.

CRISIS DEBRIEF

ADDENDUM 5

FAMILY ASSISTANCE INTERVENTION

I. Why is it important to assist families of those affected by a traumatic event?

A. Spouses and families help the person who experienced the psychological trauma readjust to normal routines!

B. Leaving families in the dark can set up a powerful negative force against the Command structure and the individual.

C. Family members want to know:

1. Details

2. Extent of trauma

3. What happened

4. What to expect

5. Homecoming celebration

II. Two major places of intervention are always possible with families.

A. Families waiting to hear if one of their members has been hurt or killed.

1. Entire network of support must be set up and maintained.

2. Key players/different theme.

B. Families of the players in a psychological trauma.

III. How to set up assistance to families.

A. Use the existing communication network. Example:

1. USS MIDWAY-Ombudsmen
   -Chaplain
   -Navy Family Services Centers

2. Haitian - Chaplain - Family Service Center to Chaplains - to wives' club - to ombudsmen

B. Find a key local person who can set up places to meet.

C. Set up convenience times for the families - usually evenings.

D. Have network do the calling to the individual wives/spouse/families.

E. Kids are welcome for those who cannot get babysitter.

F. CO/XO/CMC spouses have mailing lists and usually an excellent communication network

IV. Meet with them in uniform - officially but casually

A. Give them facts/details about the occurrence.

B. Teach Psychological Trauma Model - use handouts.

C. Teach expected reactions - use handouts.

D. Keep it to 45 minutes - many questions and informal discussion will follow.

V. Military Families are strong and generally know the physical and emotional dangers of their spouses.

A. They often <u>have</u> anticipated that something might occur.

B. Allow them to/give them permission to participate in the healing!

C. Questions most often asked:

1. Will he/she want to talk about it?

2. Should I ask?

3. Will he/she cry?

4. Is it okay to cry?

5. Will he/she be sexually dysfunctional? ("Will it affect, you know, that type of thing when he/she comes home?")

6. How much should I let him/her drink?

7. Will he/she get over it?

8. Will there be nightmares?

9. Should we make a big deal about homecoming?

VI. You will be appreciated and thanked! They feel included, and a part of the situation.

A. This can be done by proxy! Example: Chaplain in Puerto Rico.

7.7 RESOURCES

Numerous resources are available to the clinical provider through the local FSC, the community, and the Internet. Resources should be utilized in the development of groups, staff training, as well as client reference materials. Local FSCs should work to establish their own list of staff resources and client handouts. Listed below are selected Internet and professional organizations for crisis management.

Internet Resources:

International Critical Incident Stress Foundation http://www.icisf.org

The International Critical Incident Stress Foundation, Inc. is dedicated to stress prevention, education and support services for emergency services professions, organizations, and individuals with the purpose of mitigating the impact of Critical Incident Stress (Traumatic Stress).

Navy Personnel Command http://www.bupers.navy.mil/
(This site contains BUPERS Instructions, OPNAVINST, and SECNAVINST)

Contact Resources:

International Critical Incident Stress Foundation
5018 Dorsey Hall Drive
Suite 104
Ellicott City, MD 21042
(410) 730-4311

National Organization for Victim Assistance
1757 Park Road, N.W.
Washington, DC 20010
(202) 232-6682

PART EIGHT:
Strategies and Resources

8.1 OVERVIEW

In the Navy Family Service Center setting, there are abundant opportunities for effective intervention, education, and support to be provided for service members and their families. Operational readiness requirements dictate these services be provided in the most expedient manner possible. Navy instructions for FSCs require clinical counseling interventions to be short-term (OPNAV 1754.1A) in nature and focused on supporting the overall readiness of both the service member and the command. In response to instruction and to Accreditation Quality Standards, most FSCs provide interventions based on brief therapy models for their clients. The use of resource materials is another way FSC clinical providers can provide support for their clients. The goal of FSC clinical counseling services is to provide individuals with support and assistance with problems in living, to enhance quality of life for service members and their families, and to support the installation's mission and overall command readiness.

8.2 DEVELOPING A THEORETICAL ORIENTATION

The task for the FSC clinical provider is to be flexible in the application of skills while possessing a solid theoretical knowledge base. It is important for FSC clinical providers to be provided with opportunities to receive regular training in counseling modalities which would be most effective within the FSC setting.

8.3 BRIEF THERAPY

The development of brief treatment has been closely tied to the evolution of the overall mental health system in the United States. Historically, there are several explanations for this trend toward briefer therapies (Garfield and Bergin, 1986; Koss and Butcher,

1986). These include (1) the development of crisis-oriented therapies arising out of the community mental health movement; (2) the advent of the cognitive and behavioral treatments, which were originally defined as brief treatments; (3) the focus on brief therapy in research studies because of the practical difficulties of studying long term treatments; (4) the increasing awareness among clinicians that most clients desire a treatment of shorter duration; and (5) the pressures from health insurance companies to lower costs.

Clinicians and clinical providers of varying orientations as well as therapy researchers have recognized the shift toward brief therapy as the standard while long-term therapy is becoming the exception. Steve de Shazer, co-founder of Solution Focused Brief Therapy, said "I don't set out to do therapy briefly. I set out to do therapy effectively, and effective therapy tends to be brief." Brief therapy supports accomplishment of the FSC mission and supports overall personal, family and command readiness.

8.3.1 BRIEF THERAPY IN THE FSC

Cost is more important than ever as managed care approaches have come to dominate the health care environment, including TRICARE, which covers the mental health care costs of family members of active duty and retired personnel. It is not surprising FSC clinical providers, are increasingly drawn to theoretical models which specify time-limited brief therapy. The model of brief therapy is seen as responsive to the needs of the clients who are served by the FSC clinical counseling unit. A brief therapy model is also responsive to the needs of the Navy which does not commit to longer term therapy because of its (1) relocations, (2) deployments, and (3) operational commitments.

It is the responsibility of the FSC clinical provider to remain current on the implications and practice of brief treatment. The practice of planned brief therapy, and the use of a sound, empirically based theoretical framework which is goal oriented, practical, concrete, active, collaborative, and short-term (e.g., Solution-Focused Brief Therapy, Cognitive Therapy, Possibility Therapy), should be seen as the treatment option of choice for the client. Brief therapy, as a modality, is an effective treatment which can provide maximum benefits for the client in the FSC setting where time constraints are always present.

In recent years, more and more educational training programs in clinical counseling, social work, and clinical psychology are recognizing the need to teach short-term methods. There is historical evidence brief therapy is an extremely effective modality, and one which fits with the goals and philosophy of the FSC. Many proponents of Brief Therapy support the findings which conclude that extended therapy has no better outcome than short-term therapy, regardless of the type or severity of the problem.

8.3.2 UNIFYING ELEMENTS IN BRIEF THERAPIES

Koss and Butcher (1992) listed nine elements that they call "common technical characteristics of crisis oriented and brief therapy." These are summarized here:

1. *Utilization of time.* Most brief therapies have an upper limit of 25 sessions and an emphasis on brevity of treatment.
2. *Limited goals.* Specific symptoms, problems, sectors of disturbance become the focus of the treatment: a wide-ranging "character" change does not.
3. *Focused interviewing and present centeredness.* There is an attempt to keep the client focused on resolving the problem at hand rather than free association, open-ended interviewing. Clients demonstrated considerably more improvement in regard to those identified problems that are focused on than those that are not focused on.
4. *Activity and directiveness.* The therapist in brief treatment tends to talk more and interpret more, may give advice and suggestions, and assign homework, tasks.
5. *Rapid, early assessment.* For the most part, assessment and treatment in brief therapy begins almost simultaneously. Assessment and treatment are inextricably interwoven and can be one and the same. In short-term group therapy the assessment procedure itself is a group experience. Due to time constraints in most brief approaches, a clinical provider cannot provide a lengthy and extensive evaluation.
6. *Therapeutic flexibility.* The field of counseling may be headed toward a great ecumenism, with electicism becoming the dominant theoretical application for most therapists.
7. *Ventilation.* Most major proponents of brief therapy believe that the opportunity to express and ventilate emotional tension is an important element in the treatment.
8. *Therapeutic relationship.* It is of the essence that the therapist and patient quickly

develop a therapeutic alliance in brief therapy lest the treatment end before such a relationship develops. The formation of such an alliance either occurs quickly or is unlikely to occur at all in brief therapy.

9. *Selection of clients.* This is probably the most important single element in brief therapy. During the assessment process, due consideration should be given to the client's presenting problem and a determination made as to whether the problem would be effectively relieved by a brief therapy model.

Brief therapy appears to be more suitable to less disturbed clients, regardless of whether the treatment is short-term individual therapy or short-term group therapy.

8.4 GROUP COUNSELING

Many FSC clients can benefit from group counseling. Groups are useful for helping people to:

(1) learn how to relate to other people;

(2) experience giving and receiving support;

(3) improve relationships with others;

(4) communicate with others, and

(5) express themselves more assertively.

In short, group membership can be useful in helping people rehearse or regain behaviors they have not been able to use before. Groups are helpful in creating a setting for clients to engage in interaction with people different from themselves, to encounter their own values and attitudes, to gain additional information about themselves and their behavior, and to learn ways of changing their situation or handling situations more productively. Groups can be useful as a context for various aspects of growth and change.

Groups can also provide a forum for clients to address issues, to work collectively on an issue, and to participate in decision making. Clients learn collective decision making is more creative than decisions made alone because the options and resources are expanded and multiplied. Clients can discover, because of the feedback received and interaction with others, that decisions reached are more "accurate"

because the information used to solve problems/make decisions, is expanded. Clients can also discover that group decision making is more time consuming than decisions made alone. However, the range of possibilities and options available to clients, and the relatively greater accuracy of group decisions, can be perceived as more than compensating for the time used. In short, groups can be efficient and accurate for making decisions.

FSCs need to research and develop a standard operating procedure for any group offered. Careful assessment and screening should be completed before placing any client into the group setting. Groups should be evaluated regularly in accordance with Accreditation Quality Standards (Refer to Attachment 48 for Presenter Self Evaluation form).

8.4.1 CONFIDENTIALITY AND GROUP COUNSELING

Within groups a certain amount of personal, individualized, and sensitive information will be shared. The FSC clinical provider and all the group members should agree about information which is not to be shared with the group.

Personal views on subjects outside the purview of the group's purpose, for example, should not become the material for group discussion. The group cannot be the arena for relating to material irrelevant to the purpose for which the group exists. The group must remain focused on the group's goals versus the individual member's goals. The confidentiality of the group should be stressed to the group members. For example, group members should not discuss the group with friends, family, etc.

8.4.2 COST EFFICIENCY AND GROUP COUNSELING

A group does not necessarily reduce the time and cost factors of serving clients. Once a group is finally established, it becomes a cost-effective modality if the group capacity is maximized and administrative tasks are streamlined.

Even under tight fiscal constraints, cost benefits should not be a major determinant in the decision to provide group services. What should be the determinant is the assessment of possible benefit to potential clients for participating in a group, as opposed to being seen individually.

Research indicates group counseling is contraindicated for clients with certain diagnoses (For example, Axis II diagnoses such as Borderline Personality Disorder, Paranoid Personality Disorder, Schizoid Personality Disorder, Avoidant Personality Disorder, and Antisocial Personality Disorder). A determination should be made about a client's capacity to receive maximum therapeutic benefits from a group experience (e.g. the client's specific diagnosis and the degree of severity of the diagnosis).

In summary, for some clients, group counseling can be an effective treatment option. The groups offered at an FSC should be determined based on the clinical counseling staff, the resources and facilities available, and client's presenting issues. A comprehensive SOP and a trained clinical staff lay the foundation for effective and efficient group counseling.

8.4.3 PSYCHOEDUCATIONAL GROUPS

There are a variety of psychoeducational groups which can be offered by FSC clinical counseling staff. These groups should be designed as secondary prevention groups which target an identified population served by the FSC. Ideal clients are those facing or struggling with a similar problem or issue and who can respond to a combination of didactic education and group process. A clinical counseling staff member can cofacilitate this type of group with a member of the Education and Training staff who is highly skilled in program development and presentation of didactic material. Topics appropriate for consideration for a psychoeducational format include Stress Management, Parenting, and Anger Management (for nonperpetrators).

8.4.4 THERAPEUTIC GROUPS

A variety of therapeutic groups can be offered by FSC clinical counseling staff. Therapeutic groups are designed as tertiary prevention groups which target a population currently having issues or struggles with similar situations. The focus of these groups is on group process though limited didactic education and reading. Groups of this type should be facilitated only by an FSC clinical provider with clinical training, group training and experience. Presenting problems which are appropriate include Adults Molested as Children, Separation and Divorce, or Infidelity Survivors.

8.5 STRATEGIES FOR DEALING WITH JOB STRESS

FSC clinical providers are required to handle a wide range of presenting problems with a diversified client population. They provide information and referral, intake and assessment, short-term counseling, crisis intervention, and crisis response. Providers also facilitate psychoeducational and therapeutic groups, give presentations, and educate commands about FSC clinical services. They could be on board Navy ships as they return from deployment to help prepare active duty members for reuniting with their families. In some geographical areas, clinical providers are the only resource available to military families, and they personally handle every clinical client who comes through the FSC's doors.

In other FSCs, there are staff shortages and large caseloads in response to a heavy client demand. Commands call on clinical providers for advice. Providers are required to work within a system which has its own set of rules and regulations, and which can have a direct impact on the treatment plan for their clients. Providers have to be very creative to provide services to a client population who frequently moves and deploys. The Navy's advertising slogan "It's not just a job, It's an adventure" summarizes what FSC clinical providers deal with on a daily basis. The FSC clinical provider's job is challenging, and it can also be very stressful at times.

8.5.1 SUGGESTIONS FOR ALLEVIATING JOB STRESS

SUGGESTION	*IMPLEMENTATION OPTIONS AT FSC*
Flexible work scheduling	Work four 10-hour days and take Monday or Friday off each week; extend 1 hour each day and take a long weekend every other week. Facilitate an evening group and work a half day on Friday.
Arrange for job sharing of high-stress tasks.	Rotate intake schedule among clinical providers in the most equitable method. Many FSCs rotate intake daily; one busy FSC rotates intake every 4 hours.
Careful assignment of a balanced mix of clients	Each clinical provider has a balanced mix of clients in terms of type of presenting problem and complexity of case.
Job diversification and rotation	Each clinical provider has a variety of tasks: intake; facilitation of different kinds of groups (e.g., individual, marital, family); command presentations.
Supervision/Consultation	Providing 1 hour per week of individual supervision/consultation; at least 5 hours per month of group supervision; and some observation and taping of sessions.
Creating the best possible work environment	Obtaining additional office space when possible; creative use of available space; use of a telephone; space for doing groups; availability of a resource library for clinical providers; appropriate office supplies.

Education and Training	Ensuring that clinical providers receive training in areas that will assist them in working with their client population. At least once annually, FSC clinical providers attend development training.

8.5.2 RESOURCES FOR STRESS MANAGEMENT

The following list of resources may be useful in developing a personal strategy for managing stress. Information may also be shared with clients:

Internet Resources:

http://www.stressfree.com/

http://www.stressless.com/

http://www.mindtools.com/

http://www.stress.org/

8.6 RESOURCES

Numerous resources are available to the clinical provider through the local FSC, the community, and the Internet. In many cases, reading material and other resources can provide a bridge for clients to continue working toward their therapeutic goals during periods when they are unable to attend counseling sessions. Resources should be used in the development of groups, staff training, and client reference materials. Local FSCs should work to establish their own list of staff resources and client handouts. Listed below are selected published and Internet resources.

General Internet Resources:

Institute for the Study of Therapeutic Change (ISTC) http://www.talkingcure.com/
American Psychiatric Association http://www.psych.org/
American Psychological Association http://www.apa.org/
Center for Mental Health Services http://samhsa.gov/cmhs.htm

Human Services Research Institute (gopher) gopher://ftp.std.com/11/nonprofits/hsri
National Institute of Mental Health http://www.nmha.org/
Agency for Health Care Policy and Research http://www.ahcpr.gov/
American Academy of Child and Adolescent Psychiatry http://www.aacap.org/
The Clearing House http://www.mhselfhelp.org/
Federation of Families for Children's Mental Health http://www.ffcmh.org/
Internet Mental Health http://www.mentalhealth.com/
Mental Health Resources Around the World http://wpic.library.pit.edu/
Lifelines - Quality of Life Mall http://www.lifelines4qol.org
Substance Abuse and Mental Health Services Administration (SAMSHA)
http://www.samhsa.gov/
Department of Health and Human Services http://www.os.dhhs.gov/
Healthfinder ™ http://www.healthfinder.gov/
The Federal Web Locator http://www.law.vill.edu/fed-agency/fedwebloc.html
Navy Personnel Command http://www.bupers.navy.mil/
(This site contains BUPERS Directive and Instructions)
Family Therapy Links http://www.poey.demon.co.uk/links.htm
Brief Therapy Institute of Denver http://www.btid.com/
Brief Therapy Bookstore http://inetarena.com/~bneben/subdir/Bookstore.html
Possibility Therapy Homepage http://brieftherapy.com/
Brief Therapy Resources and Publications http://www.thepsychsource.html#top
Milton Erickson Foundation http://www.erickson-foundation.org

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Attachment 1

PRIVACY ACT STATEMENT FOR FSC PROGRAM

1. LEGAL AUTHORITY FOR REQUESTING INFORMATION FROM YOU: U.S. Sect. 301, which allows Secretary of the Navy to make regulations for the Department of the Navy. One of those regulations, SECNAVINST 1754.1A, Department of the Navy Family Service Center Program established the Navy Family Service Center Program.

2. PRINCIPAL PURPOSE FOR WHICH YOUR INFORMATION WILL BE USED: The information you provide will help the Family Service Center (FSC) professional staff assist you.

3. ROUTINE USES WHICH MAY BE MADE OF YOUR INFORMATION: In addition to using the information you give us for the "principal purpose" given above, your information may be used for one or more of the "routine uses" listed in the Federal Register notice for this system (including the blanket routine uses that are applicable to all Navy Privacy Act systems of records). This Federal Register notice is available here at the FSC for you to see if you wish.

Four of the more important routine uses are:

   a. disclosure to state and local government authorities in accordance with state and local laws requiring the reporting of suspected child abuse and neglect;

   b. disclosure to the appropriate federal, state, or local agency chartered with enforcing a law, where FSC records indicate that a violation of law may have occurred.

   c. disclosure to certain foreign authorities in connection with international agreements, including status of forces agreements (SOFAs); and

   d. disclosure of the Department of Justices for litigation purposes.

4. OTHER DISCLOSURE OF YOUR INFORMATION: In addition the using the information you give us for the "principal purpose" and the "routine uses" given above, your information may be disclosed in certain other specific circumstances, as permitted by exceptions to the Privacy Act. These could include clearances, personnel reliability programs, law enforcement programs, life-threatening situations, substance abuse programs, and family abuse situations.

5. DISCLOSURE IS VOLUNTARY: You need not disclose any information to us; however, failure to provide this information may hinder or prevent the FSC staff from being able to assist you.

I have read and understand the above IMPORTANT NOTICE and Privacy Act statement and the routine uses of the information which may be provided by me. My FSC counselor has explained the contents of the Privacy Act statement to me.

_____ _____
Date Signature

_____ _____
Date Witness

PRP? Yes_____ No _____

Attachment 2

RECORD OF DISCLOSURE FORM

RECORD OF DISCLOSURE – PRIVACY ACT OF 1974
OPNAV 5211/9 (Rev. 8-81)
S/N 0107-LF-052-1147

The attached record contains personal information concerning an individual.Its use and disclosure is governed by SECNAVINST 5211.5

UNAUTHORIZED DISCLOSURE OF PERSONAL INFORMATION FROM THIS RECORD COULD SUBJECT THE USER TO CRIMINAL PENALTIES

---

1. This sheet is to remain a permanent part of the record listed below.
2. An entry must be made each time the record or any information from the record is viewed by, or furnished to any person or agency, other than the subject of the record, except:
   a. Disclosures to DoD or DoN personnel having a need to know in the performance of official duties.
   b. Disclosures of items listed in paragraphs 14b (2) (e) and (f) SECNAVINST 5211.5 series.

TITLE & DESCRIPTION OF RECORD

DATE OF DISCLOSURE	METHOD OF DISCLOSURE	PURPOSE OR AUTHORITY	NAME & ADDRESS OF PERSON OR AGENCY TO WHOM DISCLOSED, WITH SIGNATURE IF MADE IN PERSON

Attachment 3

PRIVACY STATEMENT FOR SERVICE MEMBERS GOVERNED BY NUCLEAR WEAPONS RELIABILITY PROGRAM (PRP)

(See NPC 660INST 5510.11D)

The Personnel Reliability Program (PRP) is intended to ensure consistently safe performance of very sensitive duties by selected personnel. Consequently, personnel support facilities like this one are required to report potential threats to PRP participant's abilities.

> *If your helper at the Center believes your reliability is diminished or seriously threatened by your present behavior or conditions, he or she must inform you Certifying Officer, who is usually the Commanding Officer. Our report does not change your status; that decision is made by the Certifying Officer, usually after a careful review.*

Commands are often supportive of their personnel and families seeking appropriate help for their troubles. You may want to discuss your circumstances within your chain of command in order to secure official support for the steps you need to take.

I have read and understand the above statement regarding my privacy and Personnel Reliability Program

_____	_____
Date	Client
_____	_____
Date	Witness

This section is from our client confidentiality policy which covers PRP:

The conditions for decertification from the Nuclear Weapons Reliability Program can be summarized as alcohol and drug abuse, poor performance of duty, serious legal problems, significant personal difficulties, unacceptable traits (as substantiated by medical authority), and poor attitude or motivation (as contained in the PRP instruction NPC 660INST 5510.11D). Persons in this program are supposed to understand that they have surrendered some privacy in exchange for PRP certification. When it is necessary to question the current reliability of a PRP service member, the situation will be discussed with the program supervisor promptly. If the reliability concern is confirmed by this discussion, the FSC Director, will be informed. Then the assigned staff member will call the individual's command to describe the relevant aspects of the situation. If the individual was referred by the command, the referring individual will be called, and a form letter (following) will be sent to the Commanding Officer by the FSC Director. If the individual was not command referred, the Division Officer or Executive Officer will be called, followed by a Commanding Officer form letter. The Officer in Charge of a reserve unit will be called. In all instances, the FSC Director will be informed by memo.

The letter mentioned above simply states that there appears to be a problem that may reflect negatively on reliability; that we encourage the command to seek further information and consultation; and that we are prepared to assist the service member, family, and command in any way possible.

Attachment 4

SAMPLE LETTER CONCERNING STATUS OF A CLIENT'S PRP CERTIFICATION

From: Director, FSC

To: Commanding Officer

Subj: _____

Ref: (a) NPC 660INST 5510.11D

1. This letter is intended to confirm concerns about the above named service member's situation as relayed to [Command's Point of Contact] by phone on [month, date, year] by [Name and Title of FSC personnel] of our staff.

2. We are tasked with supporting command efforts to maintain reliability of personnel in sensitive assignments. We understand that we are not part of the certifying process and that Certifying Officers are encouraged to seek medical consultation when doubts about reliability arise.

3. [MAKE STATEMENT ABOUT FSCs PRESENT RELATIONSHIP WITH CLIENT(S) AND/OR ACTION INTENDED BY FSC WITH REGARD TO THEM.]

4. If we can be of further assistance to [Client(s)] or your command, please contact [Name of assigned staff member] or me at [Phone Number.]

_____

[Signature]
Director

Attachment 5

GUIDANCE FOR NFSC COUNSELORS: RELEASE OF CONFIDENTIAL INFORMATION

NOTE TO FSC COUNSELORS:

Many, but not all, records of mental health and substance abuse treatment are confidential under federal regulations (Code of Federal Regulations 42, Part 2). Disclosure of confidential information is, of course, allowed with the client's consent. However, many requests for information will come to you with client consent forms that do not comply with federal regulations. Federal law imposes an affirmative duty on you to refuse to disclose records if the request for disclosure is based on a consent form that is not legal.

The regulations are addressed in the sample forms that follow. You may add additional information. The forms should be used either to respond to requests for disclosure or whenever you request copies of a client's records from other sources.

When reviewing a consent form received with a request for disclosure, validate the client's signature. Check to determine the expiration date and whether the consent has been revoked (e.g., a client may have told a secretary or other professional that the consent has been revoked). The regulations require that the person disclosing records make a reasonable effort to determine if the consent is false. Therefore, depending on the circumstances, it may be prudent to call the client to verify the accuracy of the consent or to ask that the consent be notarized. In addition, consider whether it might be necessary to review the content of the record with the client to make certain that the client's consent is truly informed.

A signed consent to release information to a specific entity, for a specific purpose, assumes the following:

- ❑ Information will be released once. If the entity requires additional information, even within the consent's valid period, a new consent form must be executed.

- ❑ Information released will be selective and specific to the purpose. For example, if only a psychosocial history is requested, added elements of the clinical record are not to be released.

- ❑ Information obtained from a third party cannot be released by the FSC. It must be released by the original source of the information/report.

Note: Introductory information and forms reproduced with minor modifications from "A Form for Consent to Release Confidential Information," *Mental Health Legal Review,* Vol. 2, No. 6, November 1993, with permission of the publisher, Behavioral Health Services, Inc., P.O. Box 1788, Daytona Beach, FL 32115.

Attachment 6

SAMPLE RELEASE OF INFORMATION AUTHORIZATION FORM

Authority to request the following information is derived from 5 U.S.C 301, 10 U.S.C. 5031, and SECNAVINST 1754.1A. The form will be used by the officials of the Family Services Center (FSC) to assist applicants. This information may be released under one or more "routine uses" listed in the Federal Register notice for this system, including the blanket routine uses applicable to all Navy Privacy Act systems of records. Completion of this form is voluntary. Failure to provide this information, however, may hinder or prevent FSC staff from being able to assist you.

I (We) hereby authorize (agency or individual) _____

_____

_____

To release and request information regarding _____

_____

_____

_____

To and from _____

_____

For the purpose of _____

_____

_____

This permission shall remain valid for one year from date of signature.

Date _____ Client _____

Date _____ Witness _____

Attachment 7

SAMPLE REQUEST FOR INFORMATION

Name of Client: _____

Date of birth: _____

Address : _____

_____

_____

Dear Colleague:

The above-named client is currently receiving services from [name of setting]. In the best interests of client care, it would be appreciated if you would release to us the information specified below pertaining to care and services received from your organization between [month/year to month/year]. Attached is a signed authorization for release of this information. Thank you for your prompt attention and response.

_____

_____

_____

_____

_____

_____

Sincerely,

_____

[Signature]

Attachment 8

SAMPLE AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION TO CURRENT PROVIDER

I, *(name of client)* _____, ( ) request ( ) authorize *(name of program that is to make the disclosure)* _____ to disclose *(type, amount of, and time period of information to be disclosed)*_____ to *(name and practice setting to which disclosure is to be made)* _____ for the purpose of _____.

The designated information about me ___may ___may not be transmitted by fax, electronic mail, or other electronic file transfer mechanisms. The provider of the information and the recipient designated above ___may ___may not discuss by telephone the content of the information released.

This request and authorization to release information is based on my understanding of the content of my records, the use of the information once it is released, and my understanding that the source providing the information cannot be responsible for the protection of my privacy once the information is conveyed. I release the source of information from all liability arising from the release. I understand that the willingness to treat me of the party requesting information is not affected by the response of the source of the requested information. I understand that the recipient of the requested information is prohibited by federal law (Code of Federal Regulations 42, Part 2) from making any further disclosure of it without my specific written permission.

I understand that this release of information is intended to allow me to provide my informed consent for an exception to my confidentiality and the protection of my privacy guaranteed under federal law, including but not limited to the Privacy Act of 1974 (Pub. L. 93-579), the Freedom of Information Act of 1974 (Pub. L. 93-502), and the Code of Federal Regulations 42, Part 2.

This consent is subject to revocation at any time except to the extent that the program instructed to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate on *(date, event, or condition)* _____.

If this consent is to be renewed after its expiration, it may be photocopied, but it must be signed again by me and by a witness.

Signature of client:

_____

Date_____

Signature of parent or guardian (where required):

_____

Date _____

Signature of person authorized to sign in lieu of the client (where required):

_____

Date _____

Signature of witness:

_____

Date_____

Attachment 9

SAMPLE REPLY TO A REQUEST FOR CONFIDENTIAL INFORMATION

Name of client: _____

Date of birth: _____

Address: _____

_____

Dear Colleague:

We are responding to your recent request for information on the above-named individual.

[*If you can fulfill the request, use the following paragraph.*]

The requested information is enclosed. We wish to emphasize that it is strictly confidential and under federal regulations (Code of Federal Regulations 42, Part 2) it may not be disclosed by or transferred from you to anyone else without the client's further consent. Hence, do not release this material to any other party, including the client, without written consent of the client. In addition, this information is intended only for the use of professional persons capable of understanding and acting on it. We assume no responsibility if this information is conveyed to individuals not professionally prepared to interpret and use it, including the client.

[*If you cannot fulfill the request, use the following paragraph.*]

We are unable to provide the requested information because you did not send a legally executed release of information. [*Specify the problem.*] Enclosed is a form that, when properly completed and signed by indicated parties, will allow us to fulfill your request. [*Enclose a copy of your version of Authorization to a Current Provider.*]

Please contact us if we can be of further assistance.

_____

Signature

Attachment 10

SAMPLE INTAKE LOG

INTAKE LOG

FSC Counseling Service: Month:

Date:	Name/Command: Indicate Call or Walk in	Phone:	Intake Worker:	Disposition: (Scheduled appt., referral, hold, declined, lost contact)

Attachment 11

SAMPLE FSC INTAKE - REQUEST FOR SERVICES

INTAKE WORKER: _____ DATE/TIME: _____
CALLER'S NAME: _____ PHONES (H/W): _____
CLIENT'S NAME: _____ PHONES (H/W): _____
ADDRESS: _____ SPONSOR: _____
_____ DUTY STATION: _____
_____ RATE/RANK: _____
Referral Source _____
Previous Counseling: YES NO Where/When? _____

CRISIS: YES NO If yes, circle **ALL** appropriate areas:

HOMICIDAL SUICIDAL UNDETERMINED

FAP: Child Abuse/Neglect Child Sexual Abuse Spouse/Partner Abuse

# of Victims _____

PRESENTING PROBLEM: _____
_____
_____
_____

SIGNIFICANT ISSUES: _____
_____
_____

SERVICES REQUESTED: _____
_____
_____

SAFETY PLAN: NO YES (If yes, briefly describe)
_____
_____

ACTION TAKEN/DISPOSITION: _____
_____

REFERRALS TO: ___FSC ___I&R ___TRICARE ___CHAPEL

SCHEDULED APPOINTMENT TIME:

DAY/TIME/DATE: _____

COUNSELORCLINICAL PROVIDER: _____

UNIT TYPE
Air
Surface
Sub
Shore
Other _____

STATUS
In homeport
Deployed
Unacc. Tour
Geo. Bachleor
Nondeployed unit

MARITAL STATUS
Married
Single
Divorced
Separated
Widow
Single Parent
Dual Military

PRESENTING PROBLEMS
ACOA
AMAC
Blended Family
Children'/Parenting
Deployment
Family Violence
Financial
Job Related
Legal
Marital Difficulties
Stress
Substance abuse
Other _____

Client
Active Duty
Spouse
Child
Other _____

CLINICAL SUPERVISOR: _____ DATE: _____

Attachment 12

QOLMISNET SAMPLE SCREEN

MASTER CLIENT RECORD

Created:
Modified:
Updated By:

Client Information for:

SSN or ID #
Last Name:
First Name: Middle Initial:

Street Address:
City:
State: Zip/Postal Code:
Country: United States Geographic Region:

Home Telephone: ☐ Unlisted
Work Telephone:

Date of Birth: Foreign Born: ❍ Yes ❍ No

Gender: ❍ Female ❍ Male

Client's Relation to Sponsor: ❍ Child ❍ Parent ❍ Spouse ❍ Other ❍ Self

Sponsor's Status:
- ❍ Active Duty
- ❍ Reserves
- ❍ Retired
- ❍ Federal Employee
- ❍ Unknown
- ❍ Other

Ethnicity:
- ❍ African American
- ❍ Asian/Pacific Islander
- ❍ Caucasian
- ❍ Hispanic
- ❍ Native American
- ❍ Other

Education:

- ❍ Less than High School
- ❍ H.S. Equivalent/GED
- ❍ High School Diploma
- ❍ Vocational
- ❍ Some College/No Degree Completion
- ❍ Bachelor Degree
- ❍ Master Degree
- ❍ Doctoral Degree
- ❍ Other

☐ EFM Enrollee

Marriage Information

Marital Status:

- ❍ Divorced
- ❍ Dual Military Couple
- ❍ Married
- ❍ Separated
- ❍ Never Been Married
- ❍ Single
- ❍ Widowed
- ❍ Other

Date Married: No. of Times Married:

Divorce Date:

Spouse Information

Spouse SSN:

Spouse Last Name:

First Name: Middle Initial:

Street Address:

City:

State: Zip/Postal Code:

Home Telephone: ☐ Unlisted

Work Telephone:

Date of Birth: Foreign Born: ❍ Yes ❍ No

Ethnicity:

- ❍ African American
- ❍ Asian/Pacific Islander
- ❍ Caucasian
- ❍ Hispanic
- ❍ Native American
- ❍ Other

Education:

- ❍ Less than High School
- ❍ H.S. Equivalent/GED
- ❍ High School Diploma
- ❍ Vocational
- ❍ Some College/No Degree Completion
- ❍ Bachelor Degree
- ❍ Master Degree
- ❍ Doctoral Degree
- ❍ Other

Parental Status Information

CHILDREN'S NAMES AND BIRTHDATES

Children Living at Home?

- ❍ Yes
- ❍ No

Single Parent: ❍ Yes ❍ No

Sponsor Information

Sponsor's SSN:

Sponsor's Last Name:

Sponsor's First Name:

Sponsor's Middle Initial:

Military Information

Branch of Service:

- ❍ Navy
- ❍ Air Force
- ❍ Army
- ❍ Coast Guard
- ❍ Federal Employee
- ❍ Marine Corps
- ❍ Other

Sponsor's Command:

Designator/Rate:

Sponsor Rank:

❍ E1	❍ E5	❍ E9	❍ W4	❍ O4	❍ O8
❍ E2	❍ E6	❍ W1	❍ O1	❍ O5	❍ O9
❍ E3	❍ E7	❍ W2	❍ O2	❍ O6	
❍ E4	❍ E8	❍ W3	❍ O3	❍ O7	

Date Reported to Current Command:

Projected Rotation Date:

Type of Unit:

- ❍ Aviation
- ❍ Shore
- ❍ Submarine
- ❍ Surface
- ❍ Other

Deployment Status:

- ❍ Deployed
- ❍ Detached/Not a New Command
- ❍ In Home Port
- ❍ Non-deployable Unit
- ❍ Not Applicable

Housing Information

Housing Status: ❍ On-Base ❍ Off-Base

Type of Quarters:

- ❍ BEQ/BOQ
- ❍ Government Housing
- ❍ Private Housing
- ❍ Ship

Geographic Bachelor: ❍ Yes ❍ No

Civilian Employment Information

Client's Employer

Employer Name:

Address:

Sponsor of Spouse's Employer

Employer Name:

Address:

Referral Information

Client was referred by...

- ❑ CAAC/DAPA/ARC etc.
- ❑ Career Counselor
- ❑ Chaplain
- ❑ Child Development Center/FHC
- ❑ Civilian Service Agency
- ❑ Command
- ❑ Command Financial Officer
- ❑ Family
- ❑ FAP/FAR/FAS
- ❑ Friend
- ❑ ESC Staff Member
- ❑ Housing Office
- ❑ Legal
- ❑ Medical
- ❑ Military Service Agency
- ❑ Navy/Marine Corps Relief
- ❑ Other
- ❑ Red Cross
- ❑ Self

Attachment 13

SAMPLE FAMILY SERVICE CENTER MASTER CLIENT LOG

Month/Year _____

CASE NUMBER	CLIENT NAME	COUNSELOR INITIALS	PP (see below)	OPEN/REOPEN DATE	CLOSING DATE

Presenting Problem (PP)

I = Individual
M = Marital
F = Family
CAN = Child Abuse/Neglect
XA = Sexual Assault
CSA = Child Sexual Abuse
SA = Spouse Abuse

Attachment 14

SAMPLE AUTHORIZATION FOR CHILD TO RECEIVE COUNSELING AT FSC

Authorization for Child to Receive Counseling at FSC

I give permission for my child, _____, to participate in counseling at the Family Service Center, _____ until _____.

_____ _____

Parent's Signature Date

_____ _____

Witness Date

Attachment 15

SAMPLE AUTHORIZATION TO COUNSEL CHILD WITHOUT PARENTS AT FSC

Authorization to Counsel Child without Parents at FSC

I authorize the Family Service Center counselor to see my dependent child(ren) without me (or my spouse) being present. (I may cancel this authorization at any time in writing.)

(Entries are to made by client in ink)

NAME(S) OF DEPENDENT DAUGHTER(S)/SON(S). (Please print).

_____

_____

_____

_____

_____

_____

_____ _____

Patient's Name (Please Print) Parent's Signature

_____ _____

Witness Date

Attachment 16

SAMPLE AUTHORIZATION TO TAPE/OBSERVE A COUNSELING SESSION

Authorization to Tape a Counseling Session
Counseling Unit

I (we) hereby authorize Family Service Center to tape (audio or video: circle one or both) counseling sessions with _____

_____

_____

_____

for review in supervisory conferences. These tapes will be reviewed only with the Counseling Unit in the agency, and will be erased following such use.

_____ _____
Client Date

_____ _____
Witness Date

Authorization to Observe a Counseling
Session Counseling Unit

I (we) hereby authorize (agency or individual) to observe counseling sessions with

_____

_____

_____

_____

_____

for review in supervisory conferences. These tapes will be reviewed only with the Counseling Unit in the agency and will be erased following such use.

_____ _____
Client Date

_____ _____
Witness Date

Attachment 17

SAMPLE AUTHORIZATION TO DISCLOSE RECORDS TO STUDENT INTERN

Audio/Video Taping Consent and Authorization for Disclosure of Family Service Center Records to a Student Intern

(I)(We) understand that the Family Service Center participates in graduate counselor training at the Master's level with supervision and observation by an FSC-credentialed professional counselor. Pursuant to the Privacy Act, 5 U.S.C. & 522a, (I) (we) give consent to chart review and/or audio/visual recording of some sessions for supervisory training purposes.

_____ _____

Signature of Client, Parent, or Guardian Date

_____ _____

Signature of Client, Parent, or Guardian Date

_____ _____

Witness Date

Attachment 18

SAMPLE RECORD OF CONTACTS FORM

RECORD OF CONTACTS

Client's Last Name		First Name(s)		Home Phone	Work Phone
Date	Type of Session	Type of Contact Phone	Person	Individual Contacted/ Phone Referrals	Date Charted

*C = Couple I = Individual G = Group F = Family

Attachment 19

SAMPLE TREATMENT PLAN

CASE NAME _____ CASE NUMBER _____

PROBLEMS	TREATMENT GOALS	CLIENT'S STEPS TOWARD GOALS	ACCOMPLISHED YES/NO

Attachment 20

SAMPLE CLOSING SUMMARY FORM

Case Summary
Not to be removed from record

CASE NAME: _____ CASE NUMBER: _____

CASE WORKER: _____

NUMBER OF INTERVIEWS AND WITH WHOM:

TOTAL	MAN	WOMAN	FAMILY	MARITAL PAIR	OTHER (Specify)

TREATMENT SPAN: FROM _____ TO: _____

CLOSING SUMMARY: (include statement of prognosis)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Referrals Provided: Date of Referral: Date of Follow-Up/Telephone Contacts:

_____
_____
_____
_____
_____
_____

Attachment 21

SAMPLE CASE CLOSURE FORM

NOT TO BE REMOVED FROM RECORD

CASE NAME:_____ CASE NO: _____

SOCIAL SECURITY NUMBER: _____ DATE:_____

COUNSELOR:_____

REASON FOR CLOSING: _____

_____

SERVICE PROVIDED:

- ❑ Personal
- ❑ Marriage
- ❑ Family
- ❑ Parenting
- ❑ Special Needs Family
- ❑ Career Information
- ❑ Employment
- ❑ Deployment Assistance
- ❑ Financial
- ❑ Retired Affairs
- ❑ Spiritual
- ❑ Other

PROBLEM CATEGORY:

- ❑ Spouse Abuse/Neglect
- ❑ Child Abuse
- ❑ Child Neglect
- ❑ Incest
- ❑ Rape
- ❑ Sexual Assault
- ❑ Drug Abuse
- ❑ Alcohol Abuse
- ❑ Other

NUMBER OF CONTACTS:_____

TREATMENT SPAN: FROM: _____ TO: _____

REFERRALS PROVIDED: _____ DATE OF REFERRAL: _____

CLOSING SUMMARY: _____

_____

_____

WHEN CASE IS CLOSED, PLACE THIS CARD IN CLIENT RECORD.

Attachment 22

ADULT PSYCHO SOCIAL HISTORY

Date: _____ Name: _____

Name of your spouse: _____

Names and ages of children and stepchildren: _____

_____

_____

Presenting Problems: Please state the problem or problems which brought you to the Family Service Center.

_____

_____

_____

When did the problem begin? Give dates the best that you can remember. _____

_____

_____

What do you hope to achieve? How do you want us to help? _____

_____

What is going well or right in your situation right now? What are your strong points in solving problems?

_____

_____

Is the problem related to relocating (circle) TO / FROM _____. ❑ Yes ❑ No

Is it related to pre / post retirement? ❑ Yes ❑ No

FAMILY OF ORIGIN:

What are your parents names? _____

Were your natural parents married? ❑ Yes ❑ No Are they still married? ❑ Yes ❑ No

If divorced, give your age when it occurred: _____

How many brothers and their ages: _____

How many sisters and their ages: _____

Which child were you by birth? _____ Any birth/childhood problems? _____

If you were not raised by your natural parents, who raised you? _____

Has anyone in your immediate family died? _____ If so, who? _____

Does anyone in your family have alcohol/drugs, or mental health problems? _____

The problems are? _____

How would you describe the relationship your PARENTS/GUARDIANS have with each other?
- ❑ Cold – distant
- ❑ Loving – close
- ❑ Stormy – arguments
- ❑ Tolerant – put up with each other
- ❑ Abusive – verbal or physical abuse

NUCLEAR FAMILY:
Are you (circle one): Single Married Separated Divorced

Date of your present marriage: _____ Date(s) of previous marriage(s): _____

Date(s) of any previous divorce(s): _____

How would you describe the relationship between you and your SPOUSE?
- ❑ Cold – distant
- ❑ Loving – close
- ❑ Stormy – arguments
- ❑ Tolerant – put up with each other
- ❑ Abusive – verbal or physical abuse

If single, how would you describe the relationship between you and most of your past PARTNERS?
- ❑ Cold – distant
- ❑ Loving – close
- ❑ Stormy – arguments
- ❑ Tolerant – put up with each other
- ❑ Abusive – verbal or physical abuse

How would you describe the relationship between you and your MOTHER?
- ❑ Cold – distant
- ❑ Loving – close
- ❑ Stormy – arguments
- ❑ Tolerant – put up with each other
- ❑ Abusive – verbal or physical abuse

How would you describe the relationship between you and your FATHER?
- ❑ Cold – distant
- ❑ Loving – close
- ❑ Stormy – arguments

❑ Tolerant – put up with each other
❑ Abusive – verbal or physical abuse

How would you describe the relationship between you and your IN-LAWS?
❑ Cold – distant
❑ Loving – close
❑ Stormy – arguments
❑ Tolerant – put up with each other
❑ Abusive – verbal or physical abuse

SCHOOL:
What are the total number of years you have completed? _____

If college graduate, what is your degree in? _____

What kind of grades did you usually make?
____ A's _____ B's _____ C's _____ D's _____ F's

Navy schools attended/completed: _____

WORK:
What is your present job? _____ How long have you had this job? _____

How do you feel about your work?
❑ Hate it ❑ Tolerate it ❑ Like it

What future job or profession do you hope to have? _____

Would you like a referral to the Spouse Employment Assistance Program? ❑ Yes ❑ No

FINANCIAL:
How would you describe your present financial condition?
❑ Bad ❑ Fair ❑ Good ❑ Excellent

If you are having financial problems, have you sought help from any of the following?
❑ Family Service Center Counselor
❑ Command Financial Specialist
❑ Red Cross
❑ Navy/Marine Corps Relief
❑ Consumer Credit Counseling

Have you had any letters of indebtedness? ❑ Yes ❑ No

RELIGION/COMMUNITY:
Do you attend church? ❑ Yes ❑ No

What church do you attend? _____

Do you participate in any community activities or organizations? ❑ Yes ❑ No

If yes, which ones? _____

Would you like a referral to the Chaplains? ❑ Yes ❑ No

HEALTH:

My health is: ❑ excellent ❑ good ❑ fair ❑ poor

Have you ever had (circle if yes): bone fracture traffic accident head injury fight/assault

Have you ever been in the hospital? ❑ Yes ❑ No If yes, when? _____

What were you treated for? _____ List any medications: _____

Have you ever seen a (circle if yes) Psychiatrist Psychologist Social Worker Counselor

If yes, when and the reason: _____

ABUSE:

Check any of the following which have happened to you:

❑ Verbally Abused	By whom: _____	Your age: _____
❑ Physically Abused	By whom: _____	Your age: _____
❑ Sexually Harassed	By whom: _____	Your age: _____
❑ Sexually Abused	By whom: _____	Your age: _____
❑ Raped	By whom: _____	Your age: _____

ALCOHOL/DRUGS:

Check any of the following which apply to you:

- ❑ I have used drugs in the past What age:_____
- ❑ I do not use drugs at all
- ❑ I drink but do not get drunk
- ❑ I have had some problems with drinking Describe:_____
- ❑ I have been told by someone I have a problem with alcohol Who:_____
- ❑ I can drink more now than in the past
- ❑ I do not drink alcohol at all
- ❑ I drink when I feel a lot of pressure ❑ It helps ❑ It does not help
- ❑ While drinking I have had (circle): memory lapses, fights, DWIs, missed work/important events

BEHAVIOR:

- ❑ Overeating
- ❑ Vomiting
- ❑ Work too hard
- ❑ Often put things off
- ❑ Act on impulse
- ❑ Lose control
- ❑ Sleep all the time
- ❑ Cry
- ❑ Avoid fearful things
- ❑ Overspend
- ❑ Suicide attempt(s) When:_____
- ❑ Do things over and over What:_____
- ❑ Can't sleep
- ❑ Lazy
- ❑ Get mad often
- ❑ Can't eat
- ❑ Problems with friends
- ❑ Sexual problem
- ❑ Quit jobs
- ❑ Stay by myself

FEELINGS:

Check any of the feelings which currently (within the past year) apply to you:

- ❑ Angry
- ❑ Bored
- ❑ Depressed
- ❑ Contented
- ❑ Panicky
- ❑ Tense
- ❑ Guilty
- ❑ Relaxed
- ❑ Hopeless
- ❑ Regretful
- ❑ Sad
- ❑ Lonely
- ❑ Fearful
- ❑ Optimistic
- ❑ Envy
- ❑ Helpless
- ❑ Confused
- ❑ Annoyed
- ❑ Restless
- ❑ Anxious
- ❑ Excited
- ❑ Energetic
- ❑ Ashamed
- ❑ Happy
- ❑ Jealous

THOUGHTS:

- ❑ I am not very smart
- ❑ I am worthless, a nobody, useless
- ❑ I am ugly, unattractive
- ❑ I am evil, crazy, degenerative, or deviant
- ❑ I am confused and cannot think clearly
- ❑ I constantly make mistakes, can't do anything right
- ❑ I make friends easily
- ❑ People do not like me
- ❑ People pick on me
- ❑ There are people who want to hurt me
- ❑ Life is really not worth living
- ❑ I have difficulty making friends
- ❑ The Devil is trying to get me to do something horrible
- ❑ God speaks to me in a voice out loud like people do
- ❑ I know what I am getting messages over the radio or TV
- ❑ I will soon be recognized by the world for who I am
- ❑ I think life is very serious and people should take it that way

Attachment 23

YOUTH PSYCHO SOCIAL HISTORY

Date: _____ Name: _____

Mother's Name: _____ Father's Name: _____

Stepmother's Name: _____ Stepfather's Name: _____

Presenting Problems:

Why do you think you are here?

_____

_____

How do you want us to help?

_____

_____

_____

FAMILY OF ORIGIN:

Were your natural parents married? ❑ Yes ❑ No Are they still married? ❑ Yes ❑ No

If divorced, give your age when it occurred: _____

How many brothers and their ages: _____

How many sisters and their ages: _____

Which child were you by birth? _____ Any birth/childhood problems? _____

If you were not raised by your natural parents, who raised you? _____

Has anyone in your immediate family died? _____ If so, who? _____

Does anyone in your family have alcohol/drugs, or mental health problems? _____

The problems are? _____

How would you describe the relationship your PARENTS/GUARDIANS have with each other?

- ❑ Cold – distant
- ❑ Loving – close
- ❑ Stormy – arguments
- ❑ Tolerant – put up with each other
- ❑ Abusive – verbal or physical abuse

NUCLEAR FAMILY:

How would you describe the relationship between you and your BROTHERS AND SISTERS?

- ❑ Cold – distant
- ❑ Loving – close
- ❑ Stormy – arguments
- ❑ Tolerant – put up with each other
- ❑ Abusive – verbal or physical abuse

How would you describe the relationship between you and your MOTHER OR FEMALE GUARDIAN?

- ❑ Cold – distant
- ❑ Loving – close
- ❑ Stormy – arguments
- ❑ Tolerant – put up with each other
- ❑ Abusive – verbal or physical abuse

How would you describe the relationship between you and your FATHER OR MALE GUARDIAN?

- ❑ Cold – distant
- ❑ Loving – close
- ❑ Stormy – arguments
- ❑ Tolerant – put up with each other
- ❑ Abusive – verbal or physical abuse

SCHOOL:

What grade are you in? _____

Have you ever repeated a grade? _____

What kind of grades do you usually make?

____ A's _____ B's _____ C's _____ D's _____ F's

What is your favorite subject? _____

What school activities do you participate in? _____

_____

What community activities do you participate in? _____

_____

WORK:

Do you work? If yes, please explain. _____

_____

RELIGION/COMMUNITY:

Do you attend church? ❑ Yes ❑ No

What church do you attend? _____

Do you participate in any community activities/organizations? ❑ Yes ❑ No

If yes, which ones? _____

Would you like a referral to the Chaplains? ❑ Yes ❑ No

HEALTH:
My health is: ❑ excellent ❑ good ❑ fair ❑ poor

Have you ever had (circle if yes): bone fracture traffic accident head injury fight/assault

Have you ever been in the hospital? ❑ Yes ❑ No If yes, when? _____

What were you treated for? _____ List any medications: _____

Have you ever seen a (circle if yes) Psychiatrist Psychologist Social Worker Counselor

If yes, when and the reason: _____

ABUSE:
Check any of the following which have happened to you:

❑ Verbally Abused	By whom: _____	Your age: _____
❑ Physically Abused	By whom: _____	Your age: _____
❑ Sexually Harassed	By whom: _____	Your age: _____
❑ Sexually Abused	By whom: _____	Your age: _____
❑ Raped	By whom: _____	Your age: _____

ALCOHOL/DRUGS:
Check any of the following which apply to you:
❑ I have used drugs in the past What age:_____
❑ I do not use drugs at all
❑ I drink but do not get drunk
❑ I have had some problems with drinking Describe:_____
❑ I have been told by someone I have a problem with alcohol Who:_____
❑ I can drink more now than in the past
❑ I do not drink alcohol at all
❑ I drink when I feel a lot of pressure ❑ It helps ❑ It does not help
❑ While drinking I have had (circle): memory lapses, fights, DWIs, missed work/important events

BEHAVIOR:
❑ Overeating
❑ Vomiting
❑ Work too hard
❑ Often put things off
❑ Act on impulse
❑ Lose control
❑ Sleep all the time
❑ Cry
❑ Avoid fearful things
❑ Overspend
❑ Suicide attempt(s) When:_____
❑ Do things over and over What:_____
❑ Can't sleep
❑ Lazy
❑ Get mad often
❑ Can't eat
❑ Problems with friends
❑ Sexual problem
❑ Quit jobs
❑ Stay by myself

FEELINGS:

Check any of the feelings which currently (within the past year) apply to you:

- ❑ Angry
- ❑ Bored
- ❑ Depressed
- ❑ Contented
- ❑ Panicky
- ❑ Tense
- ❑ Guilty
- ❑ Relaxed
- ❑ Hopeless
- ❑ Regretful
- ❑ Sad
- ❑ Lonely
- ❑ Fearful
- ❑ Optimistic
- ❑ Envy
- ❑ Helpless
- ❑ Confused
- ❑ Annoyed
- ❑ Restless
- ❑ Anxious
- ❑ Excited
- ❑ Energetic
- ❑ Ashamed
- ❑ Happy
- ❑ Jealous

THOUGHTS:

- ❑ I am not very smart
- ❑ I am worthless, a nobody, useless
- ❑ I am ugly, unattractive
- ❑ I am evil, crazy, degenerative, or deviant
- ❑ I am confused and cannot think clearly
- ❑ I constantly make mistakes, can't do anything right
- ❑ I make friends easily
- ❑ People do not like me
- ❑ People pick on me
- ❑ There are people who want to hurt me
- ❑ Life is really not worth living
- ❑ I have difficulty making friends
- ❑ The Devil is trying to get me to do something horrible
- ❑ God speaks to me in a voice out loud like people do
- ❑ I know what I am getting messages over the radio or TV
- ❑ I will soon be recognized by the world for who I am
- ❑ I think life is very serious and people should take it that way

Attachment 24

FAMILY SERVICE CENTER CLIENT RIGHTS AND RESPONSIBILITIES

THE FAMILY SERVICE CENTER (FSC NAME) IS COMMITTED TO PROVIDING HIGH QUALITY, PROFESSIONAL CLINICAL COUNSELING SERVICES. CLINICAL PROVIDERS AT THE FSC MUST MEET NAVY REQUIREMENTS OR BE WORKING TOWARD CREDENTIALING AND LICENCING UNDER THE SUPERVISION OF A LICENSED/PRIVILEGED CLINICAL PRACTITIONER. THIS ENSURES YOU ARE PROVIDED HIGH QUALITY SERVICE.

THE GOAL OF THE CLINICAL COUNSELING DIVISION IS TO ASSIST YOU IN REACHING THE BEST SOLUTIONS, CONSIDERING YOUR PARTICULAR SITUATION. IT IS NOT THE GOAL TO "TELL" PEOPLE WHAT TO DO. IN ANY SITUATION THERE MAY BE SEVERAL SOLUTIONS, AND POSSIBLE ASSOCIATED PROBLEMS. CLINICAL COUNSELING CAN ASSIST YOU IN REVIEWING YOUR OPTIONS AND MAKING THE BEST DECISION FOR YOURSELF. DUE TO THE HIGH DEMAND, CLINICAL COUNSELING SERVICES WILL BE KEPT UNDER (# OF) SESSIONS AND GROUPS WILL BE OFFERED WHEN AVAILABLE.

ALL INFORMATION REVEALED IN CLINICAL COUNSELING WILL BE HELD IN THE STRICTEST CONFIDENCE WITH CERTAIN IMPORTANT EXCEPTIONS WHICH THE CLINICAL PROVIDER WILL EXPLAIN TO YOU WHEN THE PRIVACY ACT IS EXPLAINED. CLINICAL PROVIDERS ARE ALSO REQUIRED TO REPORT ANY SUSPECTED SECURITY PROBLEMS INVOLVING SERVICE MEMBERS IN THE PERSONNEL RELIABILITY PROGRAM, WITH SECURITY CLEARANCES AND IN AVIATION. IN THE ABOVE SITUATIONS, COMMANDS RESERVE THE "NEED TO KNOW" AND HAVE A RIGHT TO REVIEW SUCH INFORMATION.

THE CLINICAL PROVIDER YOU WILL SEE WILL BE YOUR PERMANENT FSC CLINICIAN. SWITCHING CLINICAL PROVIDERS IS NOT AUTHORIZED WITHOUT SIGNIFICANT REASON.

PLEASE NOTIFY THE CENTER IF YOU ARE UNABLE TO MAKE YOUR APPOINTMENT. CLIENT RIGHTS ARE POSTED IN OFFICES AND COMPLAINTS MAY BE DIRECTED TO THE DIRECTOR OR CHIEF OF CLINICAL SERVICES AT (PHONE NUMBERS).

I HAVE READ AND UNDERSTOOD THE ABOVE STATEMENT OUTLINING CLINICAL COUNSELING SERVICES. IF I HAVE FURTHER QUESTIONS, I WILL ASK MY CLINICAL PROVIDER FOR CLARIFICATION.

_____ _____

SIGNATURE DATE

_____ _____

WITNESS DATE

Attachment 25

SAMPLE CLIENT REFERRAL INSTRUMENT

Date: _____

Client's Name: _____

Refer To:

Name/Position _____

Agency _____

Address _____

Telephone _____

Referred By:

Name/Position _____

Agency _____

Address _____

Telephone _____

Reason for Referral: _____

_____

_____

_____

_____

Additional Information: _____

_____

_____

_____

_____

_____

Attachment 26

SAMPLE INITIAL HISTORY/ASSESSMENT FORM

CASE NAME: _____ CASE NUMBER: _____

CLINICAL PROVIDER: _____ DATE: _____

1. REFERRAL SOURCE/PRESENTING PROBLEM: _____

2. RELEVANT HISTORY: _____

3. IMPRESSIONS/ASSESSMENT: _____

4. TREATMENT PLAN: _____

_____ _____

Clinical Supervisor Clinical Provider

Attachment 27

SAMPLE CLIENT FOLLOW-UP FORM

Date:

Dear

On [month/date/year] I referred _____ to you for counseling services. In order to best serve our client population it is important to know if [name of individual] followed through on recommended services.

Please fill out the information on the lower part of this letter and return it to the Family Services Center in the enclosed envelope.

If you have any questions concerning this case, please call me at _____. Thank you for your help.

Sincerely,

Counselor: _____

Client(s) name: _____ Date of appointment: _____

Did client(s) show up for your appointment? Anticipated length of treatment: _____

❑ Yes ❑ No

Remarks: _____

_____

_____

_____

_____

Attachment 28

SAMPLE COMPLEX CASE TRACKING FORM

Date	Name of POC/Position	Agency	Phone #	Type of Contact	Outcome	Counselor's Initials

Attachment 29

SAMPLE SUPERVISOR CASE REVIEW FORM

SCALE: 1=UNSATISFACTORY; 2=MARGINAL; 3= SATISFACTORY; 4= HIGHLY SATISFACTORY; 5=OUTSTANDING

Date							
Case # / Worker							
Date Opened / Date Closed							
# Sessions							
Assessment							
Treatment Plan							
Referral Practices							
Documentation							
Case Follow-Up							
Evaluation of Clinical Services							
Supervisory Plan for Follow-Up							

Attachment 30

CLINICAL COUNSELING REVIEW FORM

TYPE OF REVIEW:

CLINICAL SUPERVISORY_____
ADMINISTRATIVE _____
PEER _____

Date_____ Counselor _____ Reviewer _____

Client name and number _____

	Yes	No	NA

1. Relevant agency forms are completed and included in record: Case Number, Privacy Act signed and witnessed; Client's Rights & Responsibilities form; Master Client Record; when appropriate, signed and witnessed Release of Information, Disclosure Log, PRP statement.

   For FAP: FAP information packet is included and signed; 2486s are completed, signed, and mailed within 30 days of the CRC; command letters are completed and mailed within 30 days of the CRC.

   ___ ___ ___

2. Intake Referral form or FAP incident Report included, when appropriate.

   ___ ___ ___

3. Initial Assessment completed: Includes adult/child psychosocial history form (completed by client) and mental status assessment and V-code diagnosis (completed by counselor).

   For FAP: Risk Assessment Model replaces the initial assessment. FAP client(s) **DO NOT** complete the demographics form.

   ___ ___ ___

4. Case Activity Notes: Case recording is clear and comprehensive; all contacts are dated, noted, and signed; client problem(s) are clearly stated; treatment plan is noted and reflects counselor's understanding of presenting problem(s).

   For FAP: Risk Assessment Model forms are used as well as case activity notes. All CRC meetings are documented in the client's record.

   ___ ___ ___

5. Appropriate and effective use of community resources and/or referrals is documented.

___ ___ ___

6. Client family members are involved in treatment, when appropriate.

___ ___ ___

7. Frequency of client contact is appropriate for identified presenting problem(s).

___ ___ ___

8. Duration of client contact is appropriate for identified presenting problem(s). Case is closed in a timely manner and includes a case summary.

   For FAP: Case is closed via the CRC recommendations.

___ ___ ___

COMMENTS: _____

_____

_____

_____

_____

_____

_____

_____

_____

Reviewed by: _____

Signature/Title

Date: _____

Attachment 31

QUARTERLY RECORDS REVIEW

It is recommended that the FSC staff member using this evaluation tool have a background in clinical counseling.

Date of Review: _____
Name of Reviewer: _____
Position: _____
Number of case files reviewed: _____ of _____

SECTION I - REFERRAL	YES	NO
1. Date of referral to Counseling Services is noted.	_____	_____
2. Source of referral is clearly indicated in record.	_____	_____
3. Date of initial contact is stated (includes phone call).	_____	_____
4. Initial contact should be made by the end of the next working day following receipt of referral for Clinical Counseling Services.	_____	_____
5. Reason for referral/request is stated.	_____	_____

SECTION II - RECORDING		
1. Recording is legible via a computer or a typewriter.	_____	_____
2. Recording includes problem statement.	_____	_____
3. Problems stated are related to request for referral.	_____	_____
4. Recording includes assessment and treatment plan.	_____	_____
5. Progress notes thoroughly describe what clinical action(s) is being taken.	_____	_____
6. Progress notes present an easily understood flow of sequential recording.	_____	_____
7. Progress notes are signed and dated for each entry.	_____	_____
8. Progress notes are sufficiently clear so that anyone picking up the case would be able to understand the case.	_____	_____
9. Closing note (comment) indicates basis for plan, outcome, and future planning where relevant.	_____	_____

SECTION III – ASSESSMENTS		
1. Information was secured from client/family/meaningful others regarding meaningful perception of total situation.	_____	_____
2. Information pertaining to current social situation is described.	_____	_____

SECTION IV - INTERVENTION	YES	NO
1. Interventions are identified.	_____	_____
2. Intervention indicated adequate involvement of appropriate family members when appropriate.	_____	_____
3. Intervention indicated adequate involvement of appropriate agencies.	_____	_____
4. Any changes in plan or goals are adequately recorded.	_____	_____
5. Documentation of presentation to Case Review/ Supervision is recorded.	_____	_____

Comments: _____

_____

_____

_____

_____

_____

_____

Attachment 32

REQUEST FOR EXTENDED CLINICAL COUNSELING SESSIONS

Client: _____ Case #: _____

Worker: _____ Date: _____

Reason for Extended Clinical Counseling Sessions: _____

_____

_____

_____

Supervisor's comments/signature: _____

_____

_____

Approved: _____ Disapproved: _____

Signature: _____ Date: _____

Attachment 33

FAMILY SERVICE CENTER CLIENT EVALUATION OF SERVICES

This questionnaire will assist the Family Service Center (FSC) staff in assessing the services offered to you and/or your family members. Your responses to all of the questions are very important and will be studied carefully so that we may continue to improve our services to military families and individuals. Thank you very much for your help.

1. How did you first hear about FSC? _____
   _____
   _____

2. What was the most important problem that brought you to the FSC? _____
   _____
   _____
   _____

3. Considering all members of your family and all problems you discussed with your counselor, how would you say things are now compared with when you first came to FSC?
   - ❑ Much better
   - ❑ Somewhat better
   - ❑ Unchanged
   - ❑ Somewhat worse
   - ❑ Better in some ways worse in others
   - ❑ No problems discussed

4. How do you feel the service provided by the FSC helped with these problems?
   - ❑ Helped a great deal
   - ❑ Helping some
   - ❑ Made no difference
   - ❑ Making things worse (Please explain): _____

5. How satisfied are you with the information and service you received?
   - ❑ Very satisfied
   - ❑ Satisfied
   - ❑ No particular feelings
   - ❑ Not satisfied (Please explain): _____

6. Is there any kind of service or help you expect or need from the FSC that you did not receive?
   - ❑ Yes
   - ❑ No (If yes, explain): _____

7. Is there anything about the FSC, its programs or policies that are causing problems for you or your family such as having to wait, distance to agency, appointment hours, change to a new counselor?
   - ❑ Yes
   - ❑ No (If yes, what was it): _____

8. Would you consider coming back to the FSC again if you need help in the future?

❑ Yes ❑ No (If no, why not?): _____

9. Would you recommend FSC services to friends or fellow workers?

❑ Yes ❑ No (If no, why not?): _____

10. How many times have you been seen at this FSC? _____

Comments: _____

_____

_____

_____

_____

_____

_____

_____

Attachment 34

CLINICAL COUNSELING QUALITY CONTROL AUDIOTAPE REVIEW

Client's Name: _____ Clinical Provider's Name: _____

Date of Session:_____ Type of Case: _____

BASIC CLINICAL COUNSELING SKILLS/ASSESSMENT

Did clinical providers demonstrate good use of:

- Joining ❑ Yes ❑ No
- Empathy ❑ Yes ❑ No
- Reflective Listening Skills ❑ Yes ❑ No
- Clarification Questions ❑ Yes ❑ No
- Open-ended Questions ❑ Yes ❑ No
- Summarizing Statements ❑ Yes ❑ No

Did clinical provider:

- Acquire client's perception of presenting problem?

❑ Yes ❑ No

FSC

Did clinical provider explain:

- FSC's role ❑ Yes ❑ No
- clinical provider's role ❑ Yes ❑ No
- Confidentiality/Navy Instructions ❑ Yes ❑ No
- Questions about privacy act or PRP ❑ Yes ❑ No

TREATMENT

Did clinical provider:

- Discuss treatment expectations and formulate goals with clients? _____

  _____
- Remain focused and provide direction for client? _____

  _____
- Assess and utilize clients strengths? _____

  _____
- Allow for exploration/ventilation of feelings? _____

  _____

TREATMENT TOOLS

Did clinical provider utilize (where appropriate) the following:

- Tracking of history of problem ❑ Yes ❑ No
- Confrontation ❑ Yes ❑ No
- Education ❑ Yes ❑ No
- Support ❑ Yes ❑ No
- Assignment of appropriate tasks ❑ Yes ❑ No
- Facilitate communication ❑ Yes ❑ No
- Normalization of emotions ❑ Yes ❑ No
- Provide appropriate interpretations ❑ Yes ❑ No

TERMINATION TRANSITION

Did clinical provider:

- Appropriately prepare client for transition to other helping systems? ❑ Yes ❑ No
- Allow client time to prepare for termination? ❑ Yes ❑ No
- Reflect on/reinforce treatment goals achieved? ❑ Yes ❑ No
- Provide appropriate referrals? ❑ Yes ❑ No

GENERAL

- Was clinical provider judgemental in any way? ❑ Yes ❑ No
- Were there any missed opportunities for intervention/treatment? _____

  _____
- What did the clinical provider excel in? _____

  _____
- What does clinical provider need to work on? _____

  _____

PLAN OF ACTION (developed by clinical provider and supervisor)

- Identify readings, supervisory focus, need for training, role plays, and so forth? _____

  _____

  _____

  _____

Attachment 35

CLINICAL PROVIDER SELF-ASSESSMENT FORM

1. How long did the interview last? _____

2. Do you feel the interview was:
   A. Too short ❑
   B. Too long ❑
   C. Just about right ❑

   If you checked A or B, explain what factors contributed to the interview being too short or too long. Who contributed most to this? What could have been done to overcome this?

   _____
   _____
   _____

3. Did the interview have a focus? ❑ Yes ❑ No

   If yes, what was the focus? _____
   _____

   If no, what prevented a focus from being developed? What could have been done to focus on the interview more? _____
   _____

4. Do you feel the client(s) received what he, she or they came for? ❑ Yes ❑ No

   If yes, what did he, she, or they get? _____
   _____

   If no, what prevented them getting what they came for? _____
   _____

5. Did the interview have a flow or interaction or continuity? ❑ Yes ❑ No

   If yes, generally describe this flow and how it was achieved. _____
   _____

   If no, what prevented flow and continuity? _____
   _____

6. Describe generally how you felt prior to the interview. _____

_____

_____

7. Describe generally how you felt during the interview. _____

_____

_____

8. Describe generally how you felt after the interview. _____

_____

_____

9. Describe your behaviors during the interview you felt good about. _____

_____

_____

10. Describe client behaviors during the interview you felt good about. _____

_____

_____

11. Describe your behaviors during the interview you felt bad about. _____

_____

_____

12. Describe client behaviors during the interview you felt bad about. _____

_____

_____

13. Are there any gestures or behaviors on your part that you are aware of that detracted from the communication process? _____

_____

_____

14. Are there any gestures or behaviors on the part of the client(s) that you are aware of that detracted from the communication process? _____

_____

_____

15. Are there any gestures or behaviors on your part that you are aware of that enhanced the communication process? _____

_____

_____

16. Are there any gestures or behaviors on the part of the client(s) that you are aware of that enhanced the communication process? _____

_____

_____

17. Are there any problems associated with this interview you would like help with? _____

_____

_____

18. Now that you have had time to think about it, what would you have done differently in this interview?

_____

_____

_____

_____

19. Based on what you know now, what are your plans for the next interview? _____

_____

_____

_____

_____

Attachment 36

SAMPLE INCIDENT REPORT

INCIDENT REPORT

Date Reported: _____ Date Incident Occurred: _____

Reported By (person): _____ Phone # of Reporter: _____

Organization: _____

Type of Abuse Reported
Check all that apply

Child	Spouse		Type of Report	
❑	❑	Physical Abuse	❑	New Incident
❑	❑	Emotional Abuse	❑	Subsequent Report
❑	❑	Sexual Abuse	❑	Transfer
❑	❑	Neglect	❑	Reopened
❑	❑	Medical Neglect		

Description of Incident
Be as specific as possible; note injuries; what led to abusive incident; include victim/witness statement.

NAVPERS 1752/2 (1-97)

INCIDENT REPORT (CONTINUED)

Eligibility Decision

- Is victim or alleged offender entitled to military medical care? YES ❑ NO ❑
- Is there imminent risk of harm to victim?

OR

- A current allegation of child/spouse/partner physical abuse, emotional abuse, neglect or child sexual abuse? YES ❑ NO ❑
- If both "YES" decide whether or not to open FAP case and continue with "Safety Assessment"
- If any "NO" responses marked, referral inappropriate for FAP. Do not open a FAP case. Provide basic assistance, e.g., telephone consult, facilitate referral to the FSC or other agency as needed, etc.

Case Status Decision

❑ Continue Assessment

❑ Close as I/R and document I/R actions taken and justification for closure below.

CASE NAME/NUMBER: _____

SIGNATURE: _____

Attachment 37

SAFETY ASSESSMENT

Assessment Factors: Using the 13 safety assessment factors listed below, determine imminent risk or harm, immediacy of response required and interventions to be initiated or maintained in order to ensure the safety of the victim or victims. Check "YES" if factor present; "NO" if factor not present; "UNKNOWN" if unknown.

		Yes	No	Unknown
1.	Dangerous acts committed.	❑	❑	❑
2.	Alleged offender has access to victim and there is imminent risk to the victim without immediate intervention.	❑	❑	❑
3.	Use of a weapon or object used as weapon.	❑	❑	❑
4.	Threats of serious harm to self or others.	❑	❑	❑
5.	Significant abuse related harm.	❑	❑	❑
6.	Failure to meet basic needs (food, clothing, shelter, supervision, etc.) which places the victim at risk for potentially serious harm.	❑	❑	❑
7.	Victim particularly vulnerable due to age, pregnancy, disability, etc.	❑	❑	❑
8.	Alleged offender has a pattern of abusive behavior.	❑	❑	❑
9.	Prior FAP reports and/or CPS reports.	❑	❑	❑
10.	Use of alcohol/drug significantly increases the risk of harm.	❑	❑	❑
11.	Fear of caretaker or spouse expressed.	❑	❑	❑
12.	Non-protective or uncooperative non-offending parent.	❑	❑	❑
13.	Other (specify)	❑	❑	❑

Any factors 1-6 checked "YES"	Immediate response required Full assessment required unless otherwise indicated
Only factors 7-13 marked "YES"	Use to prioritize response time and level of assessment Provide rationale for level of assessment needed
No factors marked "YES"	Low level of interventions are suggested

For all safety factors marked "YES" or "UNKNOWN", note the number and behaviors, conditions and/or circumstances associated with the factor.

Case Status Decision

Decision:

Case Name: _____ Case Number: _____

Signature: _____ Date Signed: _____

Attachment 38

SAFETY RESPONSE

Safety Actions: Check all actions taken or immediately planned by you or anyone else to ensure the safety of each victim. If a victim or perpetrator is now out of the home due to a safety response, identify their current location.

Notifications

Action	Date and Initial	Contact/ Comments	POC Phone

Command Action

Action	Date and Initial	Contact/ Comments	POC Phone

Safety Interventions

Action	Date and Initial	Contact/ Comments	POC Phone

Police Reports

Action	Date and Initial	Contact/ Comments	POC Phone

(Continued)

Referrals

Action	Date and Initial	Contact/ Comments	POC Phone

Counseling Services

Action	Date and Initial	Contact/ Comments	POC Phone

Current Location of Victim: _____

Current Location of Offender: _____

Case Name: _____ Case Number: _____

Signature: _____ Date Signed: _____

Attachment 39

SEXUAL ASSAULT INCIDENT REPORT/DATA COLLECTION FORM

Instructions for completing this form follow:

A. GENERAL INFORMATION:

1. Date reported: _____

2. Type of report: _____ Initial ___ Continuation (Status)

3. Name of person and command submitting report:
   _____
   Command/FSC affiliation: ____ USN ___ USMC

4. Incident Report Number a._____ b. _____ c. _____
   UIC: _____
   NCIS Case Control Number: _____

NOTE: An incident will <u>always</u> retain the same incident report number regardless of whether reporting responsibility is transferred to another installation.

B. VICTIM INFORMATION:

5. (a) Affiliation:
   - ❑ USN
   - ❑ USMC
   - ❑ USAF
   - ❑ USA
   - ❑ USCG
   - ❑ DOD Employed Civilian
   - ❑ Civilian (no military affiliation)

   (b) Status:
   - ❑ Active Duty
   - ❑ Reservist on Active Duty
   - ❑ Retired
   - ❑ Family Member (Active Duty)
   - ❑ Family Member
   - ❑ Family Member Retired

6 Age: _____

7. Gender: M / F

8. Race:
   ___ White ___ American Indian/Alaskan Native
   ___ Black ___ Asian/Pacific Islander
   ___ Hispanic Other: _____

9. (a) Initial contact/entry into Naval system:
___ Medical Treatment Facility _____ FSC
___ Base/Command Security/MPs _____ Chaplain
___ Duty Office/Quarterdeck Other:_____

(b) Date of initial contact: _____

10. Did the victim receive initial medical examination? Y/N

11. Was the victim referred for additional medical care following initial medical examination/evidence collection? Y/N

If yes, was medical care rendered at civilian or military medical treatment facility? CIV / MIL

12. Was the victim referred for counseling? Y/N

If yes, was counseling rendered at a civilian or military facility? CIV / MIL

13. Use of Alcohol/Drugs? Y / N / Unknown

C. OFFENDER INFORMATION (If known) (If more than one, use OFFENDER INFORMATION/ INVESTIGATION/RESOLUTION Continuation Sheets):

14. (a) Number of offenders: _____ (b) Offender Number: _____

15. (a) Affiliation
- ❑ USN
- ❑ USMC
- ❑ USAF
- ❑ USA
- ❑ USCG
- ❑ DOD Employed Civilian
- ❑ Civilian (no military affiliation)

(b) Status
- ❑ Active Duty
- ❑ Reservist on Active Duty
- ❑ Retired
- ❑ Family Member (Active Duty)
- ❑ Family Member
- ❑ Family Member Retired

16. Age: _____

17. Gender: M / F

18. Race:
___ White ___ American Indian/Alaskan Native
___ Black ___ Asian/Pacific Islander
___ Hispanic Other: _____

19. Relationship to victim:
    ___ Ex-Spouse
    ___ Family Member (other than spouse)
    ___ Acquaintance/Friend
    ___ Shipmate/Coworker
    ___ Girlfriend/Boyfriend
    ___ No known relationship (i.e., stranger)
    ___ Other:_____

20. Use of alcohol/drugs? Y / N / Unknown

21. Type of assault:
    _____ Rape
    _____ Indecent Assault
    _____ Indecent Exposure
    _____ Forcible Sodomy
    _____ Forcible Sodomy (same gender)

22. If the offender is found guilty, does the victim want to be notified of the offender's release? Y / N / Unknown

D. ASSAULT DYNAMICS/CIRCUMSTANCES:

23. Date of Assault: _____

24. Location of assault: (check all that apply)
    _____ On-base, U.S.
    _____ On-base, Overseas
    _____ Aboard ship, at sea
    _____ Off-base, U.S.
    _____ Off-base, Overseas
    _____ Aboard Ship, in port

E. INTERVENTION:

25. Did a victim advocate assist the victim through the following proceedings?
    ___ Medical
    ___ Investigative
    ___ Legal

    If not, why? _____

    Was the advocate of the same gender as the victim? Y / N

26. Victim's willingness to assist with investigation/prosecution. (Mark as many statements as appropriate.)
___Will (or did) submit to medical examination/evidence collection
___Statement given to law enforcement
___Willing to assist with prosecution
___Willing to testify against offender
___Unwilling to provide evidence to law enforcement

Unwillingness reasons (Optional):
___ Fear of reprisal by offender
___ Fear of reprisal by victim's superiors and/or peers
___ Fear that pursuing criminal/legal proceedings would adversely affect victim's career advancement
___ Fear of not being believed by authorities/others
___ Did not want other people to know about the assault
___ Embarrassment
___ Desire to avoid retelling, defending victim's actions
___ Unknown
___ Other: _____

F. INVESTIGATION/RESOLUTION (If more than one, use OFFENDER INFORMATION/INVESTIGATION/RESOLUTION Continuation Sheets):

27. Lead criminal investigative agency
_____ NCIS
_____ U.S. civilian law enforcement
_____ Foreign civilian law enforcement
_____ Command Security/Military Police
_____ Other: _____

28. Criminal investigation results:

(a) Was investigation initiated? Y / N

(b) Status: In progress Completed

(c) Results:
___ Resolved/Substantiated
___ Unfounded/Unsubstantiated
___ Unresolved
___ False Report

29. Offender disposition:
    (a) Administrative
        _____ Nonjudicial Punishment (NJP)
        _____ Administrative Separation
        _____ No action taken
        _____ Other: _____
        _____ Sanctions

    (b) Judicial
        _____ Summary Court-Martial
        _____ Special Court-Martial
        _____ General Court-Martial
        _____ Civilian Trial

30. Results of court-martial/civilian trial:
    _____ Guilty
    _____ Not Guilty/Acquitted
    _____ Mistrial/Case dismissed on motion prior to trial on merits

31. Charges convicted of:
    _____ Rape
    _____ Indecent Assault
    _____ Indecent Exposure
    _____ Forcible Sodomy
    _____ Forcible Sodomy (same gender)

32. If offender was found guilty, results:
    (a) Military
        _____ Discharged
        _____ Confinement/imprisonment
        _____ Forfeiture/Fine
        _____ Reduction in pay grade/Loss of lineal number
        _____ Other: _____

    (b) Civilian courts
        _____ Confinement
        _____ Fine
        _____ Mandatory counseling
        _____ Other:_____ _____

33. Did convening authority approve the results of the court-martial? Y / N
    Specify approved results _____

G. **COMMENTS:** _____
_____

Attachment 40

INSTRUCTIONS FOR COMPLETING THE SEXUAL ASSAULT INCIDENT REPORT/DATA COLLECTION FORM

QUESTION	COMMENTS
1.	Enter today's date.
2.	If this is a new incident that has not been previously reported, mark "initial". If a report was previously submitted on this particular incident, mark "continuation" on this report.
3.	Enter the name of the person who is completing the form and the command to which that person is assigned. DO NOT enter the name of the victim or assailant. Indicate whether the command/FSC submitting the report is Navy or Marine Corps.
4.	Incident report numbers are locally generated and consist of the following: a. UIC (Navy) or MCC (Marine Corps) of the installation where report is generated, b. The last two digits of the fiscal year in which the assault occurred; and
c.	The sequential number that corresponds to the number of rapes that have been reported by the reporting person's command in that fiscal year. (For example, if an installation with LYIC 12345 is submitting a report on an assault that occurred in December 1992, and this is the second assault for that fiscal year, the incident report number would be 12345-93-002.) If this is a continuation (status) report, use the incident report number that was originally assigned to the incident. Afloat commands of victims should provide assault information, by message if necessary, to the homeport installation commander for reporting purposes and to the nearest NCIS office/agent for investigation. The homeport UIC will be assigned to the report. (For example, if an assault occurs on a Pearl Harbor-based ship that is in port at Yokosuka, Japan, the reporting person at Pearl Harbor will assign NAVSTA Pearl Harbor's UIC to the report. When the ship returns to Pearl Harbor, the investigation may be transferred to NAVSTA Pearl Harbor.) The reporting installation will assign its UIC to the report and submit the initial report even when the victim is assigned to a command in another service (e.g., a Navy victim attached to a Marine Corps unit.) In this example, the Marine unit would submit the report. The Sexual Assault Incident Report/Data Collection Form is "victim-based" because victim information is usually more readily available than offender information and because response to victims is the primary concern. For cases in which it is unclear who should submit the report, consult BUPERS (NPC-661D) for guidance.

d. Enter the victim's (or victim's sponsor's) UIC.

e. Enter the NCIS case control number.

NOTE: If this a continuation report, respond only to questions not previously answered. If previously reported information has changed or subsequently been found to be incorrect, indicate in the "comments" section that answers represent new or corrected data.

5.a. If military, select one category to indicate affiliation. "DoD employed civilian" includes permanent and temporary employees, as well as vendors contracted by DoD/DoN.

5.b. If military, select status. If family member, select an affiliation category to show affiliation with military.

6. Age at the time of assault.

7. Circle M (male) or F (female).

8. Select only one category. If other, specify.

9.a. Indicate which office/department first became aware of and responded to, the incident. If other, specify.

9.b. Indicate the date when initial contact was made.

10. Indicate if the victim received an initial medical exam.

11. Indicate whether the victim required medical treatment beyond an initial physical examination/evidence collection (e.g., for injuries). If yes, specify military or civilian treatment facility.

12. Counseling may include clinical psychologist, FSC counselor, Chaplain, or community crisis center. If yes, specify military or civilian.

13. Any amount of alcohol or drug consumption immediately prior to (within approximately 24 hours of) the incident constitutes "under the influence."

14.a. List number of offenders involved in the assault. If more than one offender was involved, questions 14-19 should be answered separately for each offender on OFFENDER INFORMATION/ INVESTIQATION/RESOLUTION continuation sheets.

14.b. List offender as I of I, 1 of 2, 2 of 2, etc. as appropriate.

15.-18. Refer to explanations provided for questions 6-9.

19. Indicate offender's relationship to the victim. If living together, check other and explain.

20. Any amount of alcohol or drug consumption immediately prior to (within approximately 24 hours of) the incident constitutes "under the influence."

21. Describe the crime with which the perpetrator is charged. Refer to enclosure (1) for definitions.

22. Indicate if victim wishes to be notified of offender's release. Notification is a function of the correctional facility.

23. Give the date that the assault actually occurred.

24. If assault occurred in more than one location, check all that apply.

25. Indicate if a victim advocate assisted the victim through any of the processes, which ones, and if not, why. The SAVI Advocate can he either a military or civilian trained volunteer.

26. Indicate the victim's willingness to assist in the investigation and prosecution of the offender. Select all statement(s) that apply.

Optional screen: If "Unwilling to provide evidence" was selected in question *25,* question 26 must be answered. Select as many statements as appropriate. If further explanation is required, use comment section.

27. Indicate which agency has the lead in conducting the criminal investigation. If other, specify.

28. If investigation was opened, indicate the status/results of the criminal investigation as **determined/reported by NCIS or other lead investigating agency**. Do not make your own status determination. Generally, the response choices have the following meanings:

- Resolved/Substantiated: Sufficient evidence, conflicting information exists, cannot prove, etc.
- Unresolved: No physical evidence, insufficient evidence, conflicting information exists, cannot prove, etc.
- Unfounded/Unsubstantiated: Victim will not provide information, and so forth.
- False report. Victim admits false report, and so forth.

29 Select only one. Disposition refers only to charges of sexual assault or any lesser included offenses substituted for those charges. Other offenses with which the offender may be charged (e.g., breaking and entering in conjunction with an assault) should not be addressed. If in question 28, an incident was substantiated, question 29 must be answered. If more than one offender is being investigated/prosecuted, questions 29-32 should be answered separately for

each offender on OFFENDER INFORMATION/INVESTIGATION/RESOLUTION continuation sheets.

30. Verdict or findings refer only to charges of sexual assault or any lesser included offenses substituted for those charges. Other offenses of which the offender may be found guilty (e.g., breaking and entering in conjunction with an assault) should not be addressed. Note in the comment section if and why information regarding the verdict cannot be obtained.

31. Indicate outcome of military or civilian conviction.

32. Select appropriate response(s). If other (e.g., probation), specify.

33. Refers only to military trials.

Comments Use this section to clarify any previous answer and to provide additional Information if desired.

If final disposition of an incident has been determined or installation commander determines that further information is unobtainable due to the case being under civilian jurisdiction and this report represents the last report, state in the comments section, "Final report this incident."

THE ◆ CRISIS ◆ REACTION

The Crisis Reaction

The normal human response to trauma follows a similar pattern that some have called the crisis reaction. It occurs in all of us.

Physical Response: Characterized by physical shock, disorientation, and numbness.

"Fight-or-Flight" instinct:

- Adrenaline begins to pump through body.
- Body may relieve itself of excess materials through regurgitation, defecation, or urination.
- Heart rate increases.
- May experience hyperventilation, sweating, etc.
- May experience heightened sensory perception in at least one sense: smell, taste, sight, hearing or touch.

Emotional reaction

Stage One: Shock, disbelief, denial.
(This stage may last for only a few moments or it may go on for months.)

Stage Two: Cataclysm of emotions:

- Anger or rage: The anger may be directed at God, human error the assailant(s), family members, the criminal justice system, and even oneself. Not everyone feels anger, but many people do.
- Fear or terror: In the aftermath of a catastrophe that involves life-threatening injury or death, there is usually a sense of terror.
- Frustration: is a by-product of the feeling of helplessness and powerlessness.
- Confusion: Stems from the "why me?" question that plagues most victims. It is a question that usually has no answer. However, we tend to seek order and rationality in the world, and so the unanswered question causes more frustration.
- Guilt or shame: The feeling of guilt or self-blame may result from the mind's effort to understand the event and hence identifying behaviors or attitudes through which the victim brought the event upon himself.
- Grief or sorrow: Intense sadness over losses is not uncommon.

Stage Three: Reconstruction of Equilibrium.
(The emotional rollercoaster eventually becomes balanced.)

CRISIS ◆ INTERVENTION

Hints for Helping Immediately Following Trauma

- Limit exposure to sights, sounds and odors
- Provide an immediate rest break of at least 15 minutes
- Have a friend stay with the distressed person
- Provide fluids, non-alcoholic and non-caffienated
- Provide foods low in salt, sugar and fat
- Allow the person to talk about the experience
- Do not rush the person to return to work
- Protect the person from bystanders and the media
- Reassure the person that the stress experience is normal; most people recover very well from stress
- Show appreciation for the person's work
- Do nothing to embarrass the person
- Help the person make decisions

In the Event of Death

Don't Say:

- It's God's Will.
- You're so strong, I know you can handle this.
- Tell me what I can do.
- I understand.
- It was a blessing that ...
- He's with God now and at peace.
- I know how you feel.
- You'll get over this.
- Remember to be strong for the children.
- Just be thankful that ...
- He probably didn't know what hit him.

Do Say:

- I'm so sorry that this has happened.
- I can't imagine how difficult this must be for you.
  I'd like to be with you for a while if you don't mind.
- Would you like me to help you with ...
- It's not your fault.

SUGGESTIONS ◆ FOR ◆ LIVING ◆ THROUGH ◆ TRAUMA

Physical Preparation

- Eating habits
- Sleeping habits
- Exercise
- Indulgences

Creation of a meaning, belief and value system

Goal or purpose of orientation

Training and preparation for your goals

Plan for trauma:

- Cultivate support system: Educate, reciprocal support, explain and choose carefully.
- Time management
- Diversify activities; cultivate routines
- Information management
- Provide your own crisis intervention
- Establish a safe place for your trauma reactions.
- Allow yourself to ventilate: exercise, expressive movement, write, talk, feel.
- Predict for yourself when trauma or feelings might be most potent and construct a plan for dealing with them.
- Acknowledge trauma, its successes, and failures.

LONG-TERM ◆ CRISIS ◆ REACTIONS

Not all victim/survivors suffer from long-term stress reactions. Many victims may continue to reexperience *crisis reactions* over long periods of time. Such *crisis reactions* are normally in response to trigger events that remind the victim of the trauma.

"**TRIGGER EVENTS**" will vary with different victims but may include:

- Identification of the assailant
- Sensing (seeing, hearing, touching, smelling, tasting) something similar to something that one was acutely aware of during the trauma
- Anniversaries of the event
- The proximity of holidays or significant "life events"
- Hearing, trials, appeals or other critical phases of the criminal justice proceeding
- Media articles about a similar event

LONG-TERM STRESS or *crisis reactions* may be exacerbated or mitigated by the actions of others. When such reactions are exacerbated, the actions of others are called the *"second assault"* and the feelings are often described as a *"second injury."* Sources of the second assault may include

- The criminal justice system;
- The media
- Family, friends or acquaintances
- Clergy
- Hospital and emergency-room personnel
- Health and mental-health professionals
- Social service workers
- Victim service workers
- Schools or educators
- Victim compensation system

The intensity of long-term stress reactions usually *decreases* over time, as does the frequency of the reexperienced crisis. However, the *effects* of a catastrophic trauma **cannot** be "cured." Even survivors of trauma who reconstruct new lives and who have achieved a degree of normalcy and happiness in their lives — and who can honestly say they prefer the new, "sadder-but-wiser" person they have become — will find that new life events will trigger the memories and reactions of the trauma in the future.

Adapted from material supplied by NOVA (National Organization for Victim Assistance)

HOW ◆ TO ◆ HELP ◆ IN ◆ A ◆ CRISIS

How to Help in a Crisis

Try to be:

- Calm and accepting
- Willing to listen to painful thoughts and feelings without turning away
- Tolerant of anger or other intense emotions
- Understanding that the pain will take a long time to go away

What you can do:

- Listen, but don't force them to talk
- Let them know you understand how they feel, but avoid empty phrases
- Tell them that it is normal to feel and think and act the way they do
- Remind them to take care of themselves by seeking support of family and friends, eating good meals, getting exercise, avoiding alcohol, getting appropriate amounts of sleep.

Remember to Take Care of Yourself

Try to be:

- Concerned and caring without taking on their grief
- Accepting of your own inability to take away their pain, no matter how much you may want to
- Aware of the stress that your helping is causing you
- Understanding that the pain will take a long time to go away

What you can do:

- Avoid trying to aid too many people, sharing the grief of 2 to 3 people per day may be all you can take
- Ask someone else to take over for you if you start to feel exhausted or have difficulty maintaining your emotional "even keel"
- As soon as possible after giving aid to the bereaved, talk to one of your peers about what happened and how you feel
- Take care of yourself the same way the bereaved must take care of themselves; get support from family and friends, eat healthy meals, avoid alcohol, exercise, get adequate sleep, get recreation.

Adapted from material supplied by NOVA (National Organization for Victim Assistance).

COPING ◆ STRATEGIES ◆ FOR ◆ CHILDREN

Some Coping Strategies for Children:

- Rebuild and affirm attachments and relationships. Love and care in the family is a primary need. Extra time should be spent with children to let them know that someone will take care of them, and if parents are survivors, that their parents have resumed their former role as protector and nurturer. Physical closeness is needed.
- It is important to talk to children about the tragedy and to address the irrationality and suddenness of disaster. Children need to be allowed to ventilate their feelings, as do adults, and they have a similar need to have those feelings validated. Reenactments and play about the catastrophe should be encouraged. It may be useful to provide them with special time to paint, draw, or write about the event. Adults or older children may help preschool children reenact the event because preschool children may not be able to imagine alternative "endings" to the disaster and hence may feel particularly helpless.
- Parents should be prepared to tolerate regressive behaviors and accept the manifestation of aggression and anger especially in the early phases after the tragedy.
- Parents should be prepared for children to talk sporadically about the event; it can be helpful to spend small segments of time concentrating about particular aspects of the tragedy.
- Children want as much factual information as possible and should be allowed to discuss their own theories about what happened in order for them to begin to master the trauma or to reassert control over their environment.
- Because children are reluctant to initiate conversation about trauma, it may be helpful to ask them what they think other children felt or thought about the event.
- Reaffirming the future and talking in "hopeful" terms about future events can help a child rebuild trust and faith in his own future and the world. Often parental despair interferes with a child's ability to recover.
- Issues of death should be addressed concretely.

Attachment 47

THE HOLMES LIFE-EVENTS STRESS SCALE

If any of these life events have happened to you in the last 12 months, write the score on the appropriate line. Add all entries in the Score Column and record the total at the bottom.

ITEM VALUE	YOUR SCORE	LIFE EVENT
100	_____	Death of a spouse
73	_____	Divorce
65	_____	Marital separation
63	_____	Jail term
63	_____	Death of close family member (except spouse)
53	_____	Major personal injury or illness
50	_____	Marriage
47	_____	Fired at work
45	_____	Marital reconciliation
45	_____	Retirement
44	_____	Change in health of family member (not spouse)
40	_____	Pregnancy
39	_____	Sex difficulties
39	_____	Gain of new family member
38	_____	Business readjustment
37	_____	Change in financial state
36	_____	Death of a close friend
35	_____	Change to a different occupation
31	_____	Change in number of arguments with spouse
30	_____	Mortgage over $10,000
29	_____	Foreclosure of mortgage or loan
29	_____	Change in responsibilities at work
20	_____	Son or daughter leaving home
28	_____	Trouble with in-laws
26	_____	Outstanding personal achievement
26	_____	Spouse begin or stop work
25	_____	Begin or end school
24	_____	Change in living conditions
23	_____	Change in personal habits (self or family)
20	_____	Trouble with boss
20	_____	Change in work hours or conditions
20	_____	Change in residence
19	_____	Change in schools
19	_____	Change in recreation
19	_____	Change in church activities
18	_____	Change in social activities
17	_____	Mortgage or loan less than $10,000
16	_____	Change in sleeping habits
15	_____	Change in number or family get-togethers
13	_____	Change in eating habits
13	_____	Vacation
12	_____	Christmas
11	_____	Minor violations of the law
TOTAL	_____	

A study reveals that individuals who accumulate more than 200 points in a given year may develop physical or psychological stress-related illnesses.

Attachment 48

PRESENTER SELF-EVALUATION FORM

PROGRAM: _____ COMMAND: _____
PRESENTER: _____ POC: _____
DATE: _____

1. LOCATION OF PROGRAM:
   - ❑ FSC ❑ Shore Command ❑ Other
   - ❑ Onboard ship ❑ Squadron Building

2. SUITABILITY OF LOCATION: (i.e., seating, temperature, sound, size, etc.)
   - ❑ Excellent ❑ Good ❑ Adequate ❑ Poor ❑ Terrible
   - Comments: _____

3. SIZE OF AUDIENCE:
   - ❑ Less than 10 ❑ Between 10 - 20 ❑ Between 20 - 50 ❑ Greater than 50
   - Comments: _____

4. COMPOSITION OF AUDIENCE:
   - ❑ Active Duty ❑ Family Members ❑ Mixed
   - ❑ Attendance Voluntary ❑ Attendance Mandatory
   - Comments: _____

5. VISUAL AIDS AND/OR HANDOUTS USED:
   - ❑ Overheads ❑ Flip Chart ❑ Slides ❑ FSC Generic Handouts
   - ❑ Program Handouts ❑ Scrapbooks ❑ Nothing
   - Comments: _____

6. SUPPORT ROLE OF SPONSOR:
   - Were you supported by your sponsor? ❑ Yes ❑ No
   - Explain _____
   - Do you know anything about this command that might have affected the program? _____

7. HOW WELL DO YOU THINK YOU DID IN PRESENTING THIS PROGRAM?
   - ❑ Excellent ❑ Good ❑ Adequate ❑ Poor ❑ Terrible
   - Comment on any positive points or problem areas: _____

8. DID YOU DO ANYTHING NEW OR DIFFERENT? ❑ Yes ❑ No
   - WHAT WAS THE RESPONSE? _____

9. SUGGESTED CHANGES TO PRESENTATION: _____
   _____